Calgary Stroke Program

Improvements in Patient Flow

Michael Suddes
Manager, Calgary Stroke Program, Units 111 and 100 FMC

On behalf of Calgary Stroke Program and Partners
Disclosure (1)

I am currently working with the excellent people of Saskatoon Health Region on a Canadian Stroke Network grant funded project
Disclosure (2)

An expert is someone from somewhere else .... with slides

American Stroke Nursing Manual
Main messages

• There is a strong relationship between patient flow and EBP in stroke care
• Patient flow in stroke care **should** be improved
  – System performance
  – Clinical outcomes
• Patient flow in stroke care **can** be improved
• Several success factors will be involved in doing so
Overview

• Calgary Stroke Program (CSP) profile
• Patient flow and evidence based stroke
• Quality of stroke care in Canada
• Cross –continuum examples of CSP improvements in flow
• Key success factors
SUCCESS
Because you too can own this face of pure accomplishment
CSP clinical overview

- 1600 stroke admissions annually
- Over 85% to FMC
- 2 – 4 hyperacute ICU step down beds
- 17 acute stroke beds (80%)
- 15 + 45 tertiary rehab beds (20%)
- ESD (11%)
- Community Accessible Rehabilitation (20%)
- SPC / Physiatry clinics
- Stroke Fellowship Program and 24/7 stroke team (NP)
- Telehealth links to three Primary Stroke Centres
- Stroke Liaison Nurse, Peer Support Program, TCD service, Patient Passport, Self management programs
Patient flow and evidence based stroke care

- TIA care
- Thrombolysis (and endovascular care)
- Stroke Units and LOS
- Access to rehab and outcomes
- Early Supported Discharge and LOS/outcomes
NINDS tPA Stroke Study:
Time to Treatment and Odds Ratio of Favorable Outcome

Minutes
Stroke Onset To Start of Treatment

Odds Ratio
Favorable Outcome

Benefit for rt-PA
No Benefit for rt-PA

Four fold increase
In chances of good outcome
60 mins vs. 180 mins
The EXPRESS Study: Effect of rapid treatment of TIA

80% reduction in stroke rates

A line graph showing the functional recovery (%) over weeks for different levels of severity:

- Mild
- Moderate
- Severe
- Very severe

The x-axis represents the weeks, ranging from 0 to 25, and the y-axis represents the functional recovery (%) from 0% to 100%.
Stroke units and ESD

• Stroke units
  – save lives, reduce disability and reduce LOS

• ESD
  – Reduced LOS
  – Not more expensive
  – Improved reintegration
Summarizing the evidence

• Time is brain
  – Initial outcome
  – Secondary (stroke) prevention
  – Rehabilitation

• Organised stroke care (TIA, Stroke Unit, ESD) improves system performance and reduces cost
Quality of Canadian stroke care

- Chart review (min 20% of all acute hospital patients) 2008/9
- Cost avoidance analysis
- Most of the time, most people don’t receive best practices
- OFIs in hyperacute, acute, rehabilitation, prevention, reintegration
  - Thrombolysis times
  - Access to TIA care
  - Hospital LOS
  - Access to rehab
  - Access to telestroke
## National scorecard

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target (BPR/AC)</th>
<th>Canada</th>
<th>Alberta</th>
<th>CSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>% ischaemic patients receiving tPA</td>
<td>7%</td>
<td>8%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>DTN time (median)</td>
<td>60 min</td>
<td>72 min</td>
<td>78 min</td>
<td>50 min</td>
</tr>
<tr>
<td>% receiving tPA in 1 hour</td>
<td>100%</td>
<td>34%</td>
<td>35%</td>
<td>66%</td>
</tr>
<tr>
<td>% patients treated on a stroke unit</td>
<td>75%</td>
<td>23%</td>
<td>41%</td>
<td>82%</td>
</tr>
<tr>
<td>% patients with a swallow screen</td>
<td>90%</td>
<td>50%</td>
<td>44%</td>
<td>100%</td>
</tr>
<tr>
<td>Acute LOS (median)</td>
<td>&lt; 14</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>
## CSP flow improvement interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Type of approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute stroke unit implementation</td>
<td>Design</td>
</tr>
<tr>
<td>tPA administration</td>
<td>Six Sigma</td>
</tr>
<tr>
<td>Access to Rehabilitation</td>
<td>Redesign</td>
</tr>
<tr>
<td>Early Supported Discharge (ESD)</td>
<td>Design / LEAN</td>
</tr>
<tr>
<td>Stroke Prevention Clinic access</td>
<td>LEAN</td>
</tr>
<tr>
<td>TIA Access (TIARA Clinic)</td>
<td>Design</td>
</tr>
</tbody>
</table>
Access to rehab

• Previously
  – High LOS on IP rehab
  – Lack of clarity/consistency re assessments and disposition
  – Long waits from rehab ready to transfer

• Goals
  – provide timely access to quality service
  – facilitate the seamless transition of clients across acute, community and rehabilitation services

• Improvement approach
  – System wide summit event
  – Address governance structure
  – Redesign task force
New process

- early referral
- single OT coordinator
- patient screened
- rehab service to match patient need
- info transferred
## New criteria

<table>
<thead>
<tr>
<th>FMC Unit 58</th>
<th>VF Neuro Rehab</th>
<th>Early Supported Discharge</th>
<th>Community Accessible Rehab</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Moderate</td>
<td>• Moderate</td>
<td>• Mild to moderate disability</td>
<td>• Functional treatment goals</td>
</tr>
<tr>
<td>• Invasive medical needs</td>
<td>• Few acute care issues and low nursing needs</td>
<td>• Medically stable</td>
<td>• Complex needs needing multi-disc approach</td>
</tr>
<tr>
<td>• More acutely ill</td>
<td>• 4 beds for young, severe stroke survivors</td>
<td>• Help to transition</td>
<td>• Acute neuro event and rehab needs to restore function</td>
</tr>
<tr>
<td>• Ongoing medical</td>
<td>with expected d/c of home</td>
<td>• Transfer X 1 or Ind.</td>
<td>• Degen neuro cond requiring assess/tx for meaningful function</td>
</tr>
<tr>
<td>investigations</td>
<td></td>
<td>• Within Calgary limits</td>
<td>• Medically stable and can participate in active program</td>
</tr>
<tr>
<td>• Requires a locked unit</td>
<td></td>
<td>• Prevent short stay in rehab</td>
<td>• At risk for admission or re-admission to hosp.</td>
</tr>
<tr>
<td>• 50 years old or less</td>
<td></td>
<td>• Up to daily frequency</td>
<td></td>
</tr>
<tr>
<td>(preferred)</td>
<td></td>
<td>• Best served in home/community</td>
<td></td>
</tr>
</tbody>
</table>
Stroke - INPT - Unit 658 Median Total Length of Stay (VFC)

Redesign
ESD

- Comprehensive interprofessional rehabilitation service that links inpatient care with community resources
- Intensive rehabilitation service for individuals with mild or moderate disability following stroke
- Provides the opportunity for clients to return home after a shorter hospital stay following acute stroke
- Piloted or operational now in 8 teams across 5 Provinces
Utilization and efficiency

• Intake
  – From acute IP (66%)  87% meet target of 2 days
  – From rehab IP (34%)  90% meet target of 3 days

• Length of service
  – Target of 20-40 days  mean 25 days, median 24 days

• Output
  – No service 60%
Clinical effectiveness

• Functional gain
  – COPM 100% of clients experienced improvement
  – FIM 94% experienced improvement
  – AusTOMs 98% demonstrated improvement across one or more of the domains

• Client experience
  – 100% would recommend to a family member/friend
Stroke - INPT - Median ACUTE LOS (Cal Urban)
Site = ALL

ESD implemented
Stroke - INPT - Pts having a portion of their Stay on PCUs 100/112 (FMC)

ESD implemented
Stroke - ED Visits - Median Wait Time Pts Admitted to All PCUs (FMC)

ESD implemented
Stroke Accred - Readmission to Acute Care w Stroke Related Causes
Stroke Type = ALL

Fiscal Qtr Start Date

ESD implemented
tPA administration

- 2 x Six Sigma projects (HASTE I and II)
- DMAIC
  - Define
  - Measure
  - Analyse
  - Improve
  - Control
- HASTE 1 – Measurement System Analysis and reporting
- HASTE 2 – Triage to Decision process changes
Six Sigma: HASTE 2 – Measure and Analyse Phases

How and What

• Informed by Define Phase
  – Critical X’s
  – Y’s
  – Sub-Y’s

• Prospective data collection by:
  – In real-time by ED Triage RN
  – In real-time by Stroke Dr.
  – Electronic clinical info systems
  – Paper medical record

• N = 112 patients
Six Sigma: HASTE 2 – Improve & Control Phases

• Test and implement a “STAT! Stroke” Protocol
  – Re-designing the process for parallel processes, not serial work
  – Minimize delays in getting Pt. to CT Suite for DI
    • Communication between EMS and Triage upfront
    • Standard Work
    • Addressing registration delays via Unknown Pt Default
• Sustain the gains through measurement, feedback, education, communication
## HASTE Project: Standard Work DRAFT V3 – February 28th 2013

### Part 1: Definition for Stages of the Process

<table>
<thead>
<tr>
<th>Stage of Process</th>
<th>Which Team Members are Involved</th>
<th>Goal(s) of the Team’s activity in this stage</th>
<th>Start Point</th>
<th>End Point</th>
<th>Target Time</th>
<th>Remarks</th>
</tr>
</thead>
</table>
| EMS On-Scene with Patient | ✓ Patient  
✓ Witness  
✓ EMS Paramedic #1  
✓ EMS Paramedic #2 | Ensure Pt’s safety  
Identify acute disabling stroke via Stroke Screen | Begins: [EMS definition]  
Ends: [EMS definition] | NA |             |                     |
| Pre-Hospital Patch      | ✓ EMS Paramedic #1 or 2  
✓ EMS Dispatcher  
✓ FMC ED Triage RN | Transfer required and relevant information about the Pt to Team at FMC.  
Facilitate activation of downstream steps of the process | Begins: EMS Paramedic #1 or 2 places patch call (via cell phone or via EMS Dispatch)  
Ends: Patch communication ends and Triage RN hangs up phone in ED | Target: ≤ 5 minutes required for conversation and Triage RN documentation |             |                     |
| Preparing for Patient’s Arrival in ED *PARALLEL PROCESSES* | ✓ Triage RN  
✓ Unit Clerk  
✓ Admitting Clerk  
✓ ED MD  
✓ Nancy  
✓ Stroke Fellow  
✓ ED Pt Care Attendant | Activate team. Prepare to physically receive the Pt (bed, equipment).  
Look-up critical information about Pt’s medical history (NetCare) so it is available to integrate into decision-making on arrival. | Begins: Triage RN passes Activation Sheet to Unit Clerk  
Ends: ED MD and Stroke Fellow / Nancy discuss patient | Target: ≤ 10 minutes required to prep for arrival |             |                     |
| EMS Arrival at Triage   | ✓ Patient  
✓ Witness  
✓ EMS Paramedic #1  
✓ EMS Paramedic #2  
✓ Triage RN  
✓ Admitting Clerk  
✓ ED MD  
✓ Nancy  
✓ Stroke Fellow | Pt registered as Unknown in REDIS and Clinibase | Begins: EMS rolls patient through ED doors  
Ends: Team, Pt, Witness initiate depart triage for pre-assigned ED bed | Target: ≤ 1 minute required for stop at Triage |             |                     |
<table>
<thead>
<tr>
<th>EMS</th>
<th>ED Triage RN</th>
<th>Unit Clerk</th>
<th>Admitting Clerk</th>
<th>ED Pt Care Attendant</th>
<th>ED Physician</th>
<th>Nancy, Stroke Fellow (00379)</th>
<th>Family Member / Witness</th>
</tr>
</thead>
<tbody>
<tr>
<td>- bring patient to ED Triage from Ambulance Bay</td>
<td>- complete REDIS registration (classify as CTAS Level 1; enter REDIS orders)</td>
<td>- Watch computer screen for the patient to appear as registered in REDIS and activate in Clinibase at that time</td>
<td>- Present at Triage to ‘lay eyes’ on patient and begin Safe for CT assessment</td>
<td>- Present at Triage to ‘lay eyes’ on patient and begin stroke neuro assessment</td>
<td>- Present at Triage to ‘lay eyes’ on patient and begin stroke neuro assessment</td>
<td>- Present at Triage to ‘lay eyes’ on patient and begin stroke neuro assessment</td>
<td></td>
</tr>
<tr>
<td>- proceed to pre-assigned ED bed location</td>
<td>- Give Unknown Pt Chart Forms to ED MD</td>
<td>- indicate pre-assigned ED bed location</td>
<td>- request information from EMS if needed</td>
<td>- (heads-up communication to floor RNs, PCA, others?)</td>
<td>- Activate patient in SCM</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>
The following data has been collected using a retrospective chart review and electronic data sources. The various data components are captured from the following locations:

**Door Time:** The door time is captured from the Emergency Department Sheet that is generated and time stamped automatically when patient triage has been completed. If the patient is logged as an unknown patient, the time is captured manually by the emergency department; in this case, the data is collected from the same form except that we look for a manual time stamp as opposed to an automatic time stamp. The majority of the time, an automatic time stamp is collected.

**CT Time:** The CT time is captured from the PACS electronic database as captured and recorded by the time on the CT scanner.

**Intravenous-Needle Time:** For tPA administered in the Emergency Department, time is captured from the Emergency Department nursing notes medications sheet. For tPA administered on Unit 112, time is captured from the flow sheet, nursing notes.

### Intravenous Treatment and Intravenous + Endovascular Treatment

<table>
<thead>
<tr>
<th>N</th>
<th>Week</th>
<th>Route</th>
<th>Door to CT</th>
<th>CT to Needle</th>
<th>Door to Needle</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>June 1 – June 7</td>
<td></td>
<td>0:14</td>
<td>0:18</td>
<td>0:32 Median</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV+endo</td>
<td>0:06</td>
<td>0:19</td>
<td>0:25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV</td>
<td>0:23</td>
<td>0:17</td>
<td>0:40</td>
</tr>
<tr>
<td>68</td>
<td>Jan 1, 2012 – June 7, 2012</td>
<td></td>
<td>0:21</td>
<td>0:24</td>
<td>0:48 Year to Date – Median</td>
</tr>
<tr>
<td>16</td>
<td>May 1 – May 31</td>
<td></td>
<td>0:23</td>
<td>0:28</td>
<td>0:49 May 2012 - Median</td>
</tr>
<tr>
<td>36</td>
<td>Jan 1, 2012 – March 31, 2012</td>
<td></td>
<td>0:22</td>
<td>0:22</td>
<td>0:48 Previous Quarter - Median</td>
</tr>
<tr>
<td>120</td>
<td>Jan 1, 2011-Dec 31, 2011</td>
<td></td>
<td>0:24</td>
<td>0:33</td>
<td>1:02 Previous Year - Median</td>
</tr>
</tbody>
</table>

**Legend:**
- **IV:** Ischemic stroke patients treated with Intravenous tPA;
- **IV+endo:** Ischemic patients treated with Intravenous tPA along with an endovascular method using tPA or an endovascular device

**Endovascular-Needle Time:** The groin puncture time is captured as the needle time for Endovascular cases. This time is located on the Diagnostics Imaging flow sheet, in the nursing notes.

### Endovascular Only

<table>
<thead>
<tr>
<th>N</th>
<th>Week</th>
<th>Route</th>
<th>Door to CT</th>
<th>CT to Groin Puncture</th>
<th>Door to Groin Puncture</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>June 1 – June 7</td>
<td>Endo</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td>Jan 1, 2012 – June 7, 2012</td>
<td></td>
<td>0:20</td>
<td>0:49</td>
<td>1:20 Year to Date - Median</td>
</tr>
<tr>
<td>1</td>
<td>May 1 – May 31</td>
<td></td>
<td>0:23</td>
<td>0:57</td>
<td>1:20 May 2012</td>
</tr>
<tr>
<td>10</td>
<td>Jan 1, 2012 – March 31, 2012</td>
<td></td>
<td>0:19</td>
<td>0:45</td>
<td>1:18 Previous Quarter - Median</td>
</tr>
<tr>
<td>16</td>
<td>Jan 1, 2011-Dec 31, 2011</td>
<td></td>
<td>0:22</td>
<td>0:45</td>
<td>1:12 Previous Year - Median</td>
</tr>
</tbody>
</table>

**Legend:**
- **Endo:** Ischemic stroke patients treated with endovascular device including tPA
YOU CAN'T TEACH AN OLD DOG NEW TRICKS
Key success factors

1. Manage your quality
2. Measure performance against best practice relentlessly
3. Report performance regularly and engage the team
4. State of the art improvement for state of the art care
5. Don’t take your own word for it
6. Celebrate your success
1. Manage your quality

“all models are wrong – some are just more useful than others ...”

George Box
Lean: (broad and shallow)
Six Sigma: (narrow and deep)
Design / Redesign

Supporting processes:
- Strategic Planning
- Patient/Family Involvement
- Leadership Development
- Patient Safety
- Learning & Development
- Staff Focus
- Finance

State of the Art Process Improvement & Design
- LEAN: (broad and shallow)
- Six Sigma: (narrow and deep)
- Design / Redesign

Performance Measurement & Evaluation

Internal
- Supporting process metrics
- Clinical process metrics
- Accreditation Canada
- Benchmarking
2. Measure performance against best practice relentlessly
3. Report performance regularly and engage the team
Calgary Stroke Program
Weekly Report – Door to Needle Times
Update: June 1 – June 7

The following data has been collected using a retrospective chart review and electronic data sources. The various data components are captured from the following locations:

Door Time: The door time is captured from the Emergency Department Sheet that is generated and time stamped automatically when patient triage has been completed. If the patient is logged as an unknown patient, the time is captured manually by the emergency department; in this case, the data is collected from the same form except that we look for a manual time stamp as opposed to an automatic time stamp. The majority of the time, an automatic time stamp is collected.

CT Time: The CT time is captured from the PACS electronic database as captured and recorded by the time on the CT scanner.

Intravenous-Needle Time: For tPA administered in the Emergency Department, time is captured from the Emergency Department nursing notes-medication sheet. For tPA administered on Unit 112, time is captured from the flow sheet, nursing notes.

### Intravenous Treatment and Intravenous + Endovascular Treatment

<table>
<thead>
<tr>
<th>N</th>
<th>Week</th>
<th>Route</th>
<th>Door to CT</th>
<th>CT to Needle</th>
<th>Door to Needle</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>June 1 – June 7</td>
<td>IV+endo</td>
<td>0:14</td>
<td>0:18</td>
<td>0:32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV</td>
<td>0:23</td>
<td>0:17</td>
<td>0:40</td>
</tr>
<tr>
<td>68</td>
<td>Jan 1, 2012 – June 7, 2012</td>
<td>IV+endo</td>
<td>0:21</td>
<td>0:24</td>
<td>0:48</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV</td>
<td>0:23</td>
<td>0:28</td>
<td>0:49</td>
</tr>
<tr>
<td>16</td>
<td>May 1 – May 31</td>
<td>IV+endo</td>
<td>0:22</td>
<td>0:22</td>
<td>0:48</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV</td>
<td>0:24</td>
<td>0:33</td>
<td>1:02</td>
</tr>
<tr>
<td>36</td>
<td>Jan 1, 2012 – March 31, 2012</td>
<td>IV+endo</td>
<td>0:22</td>
<td>0:22</td>
<td>0:48</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV</td>
<td>0:24</td>
<td>0:33</td>
<td>1:02</td>
</tr>
<tr>
<td>120</td>
<td>Jan 1, 2011-Dec 31, 2011</td>
<td>IV+endo</td>
<td>0:24</td>
<td>0:33</td>
<td>1:02</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV</td>
<td>0:24</td>
<td>0:33</td>
<td>1:02</td>
</tr>
</tbody>
</table>

**Legend**
- IV: Ischemic stroke patients treated with Intravenous tPA
- IV+endo: Ischemic patients treated with Intravenous tPA along with an endovascular method using tPA or an endovascular device

Endovascular-Needle Time: The groin puncture time is captured as the needle time for Endovascular cases. This time is located on the Diagnostics Imaging flow sheet, in the nursing notes.

### Endovascular Only

<table>
<thead>
<tr>
<th>N</th>
<th>Week</th>
<th>Route</th>
<th>Door to CT</th>
<th>CT to Groin Puncture</th>
<th>Door to Groin Puncture</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>June 1 – June 7</td>
<td>Endo</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td>Jan 1, 2012 – June 7, 2012</td>
<td>Endo</td>
<td>0:20</td>
<td>0:49</td>
<td>1:20</td>
</tr>
<tr>
<td>1</td>
<td>May 1 – May 31</td>
<td>Endo</td>
<td>0:23</td>
<td>0:57</td>
<td>1:20</td>
</tr>
<tr>
<td>10</td>
<td>Jan 1, 2012 – March 31, 2012</td>
<td>Endo</td>
<td>0:19</td>
<td>0:45</td>
<td>1:18</td>
</tr>
<tr>
<td>16</td>
<td>Jan 1, 2011-Dec 31, 2011</td>
<td>Endo</td>
<td>0:22</td>
<td>0:45</td>
<td>1:12</td>
</tr>
</tbody>
</table>

**Legend**
- Endo: Ischemic stroke patients treated with endovascular device including tPA
Median Door to Needle Time for tPA Administration
March 2010 - February 2013 (IV, IV+endo cases)

n = 400
Max = 1:47
Min = 0:37

Running Average
(of monthly median times)
64 min (mar 10-oct 11)
49 min (oct 11-feb 13)
4. State of the art improvement for state of the art care

<table>
<thead>
<tr>
<th>Approach</th>
<th>Frontline led</th>
<th>Data Driven</th>
<th>Quick</th>
<th>Evidence based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quick wins</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>LEAN (streamline)</td>
<td>+++</td>
<td>++</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Six Sigma (analytical/data)</td>
<td>++</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Design/Redesign</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>++</td>
</tr>
</tbody>
</table>
5. Don’t take your own word for it: Stroke Distinction Process

- Team Prep
- Survey Visit
- Award Decision

Baseline performance measures

Six monthly performance measures

6 months

24 months

Revise strategic plan and engage in quality improvement activities
Impact (1)

- All clinical services but principally in
  - hyperacute care
  - rehabilitation
- All supporting processes apart from Finance
- Galvanised our Performance Measurement Plan
- Promoted partnerships
- Drove the strategic direction for our QI
  - within
  - outwith the Program
“How did you go bankrupt”, asked Bill.

“In two ways” replied Mike....

... “gradually then suddenly... ”
6. Celebrate your success
Main messages

- There is a strong relationship between patient flow and EBP in stroke care
- Patient flow in stroke care should be improved
  – System performance
  – Clinical outcomes
- Patient flow in stroke care can be improved
- Several success factors will be involved in doing so
THANK YOU
YOU ARE AWESOME!