Improving Access to Stroke Care in the Rural Setting: The Journey to Acute Stroke Ready Designation

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Problem: Stroke is the fifth highest cause of death and the leading cause of long-term disability in the United States. North Carolina has one of the highest death rates from stroke in the nation. Access to acute stroke care in rural western North Carolina is limited, with only one primary stroke center within an 18-county region. Angel Medical Center, located in rural western North Carolina, sought to pursue The Joint Commission's disease-specific certification as an Acute Stroke Ready Hospital in an effort to improve stroke care and outcomes across the region.

Methods: A multidisciplinary team of ED clinicians, hospital leadership, and community participants was formed to develop a structured care algorithm and intensive process improvement initiatives to guide the Acute Stroke Ready Hospital application process.

Results: In the 7 months since implementation, door-to-laboratory results have improved by an average of 12 minutes, door-to-computed tomography interpretation has improved by 3 minutes, time to intravenous thrombolytics has improved to less than 60 minutes, and patient transfer within 2 hours of arrival has also improved. ED provider average response time has been reduced by 5 minutes, and time to neurology via telemedicine has been reduced by almost 10 minutes.

Implications for Practice: By driving best practices in the delivery of stroke care, Angel Medical Center enhanced stroke care in a rural community, allowing patients and families to receive evaluation and treatment in a timely and efficient manner close to home.

Nearly 800,000 people in the United States are affected by a stroke each year. Stroke ranks as the fifth highest cause of death and the leading cause of long-term disability.[1] Stroke is the fourth leading cause of death in North Carolina, which has one of the highest stroke death rates in the US,[2] with an age-adjusted stroke rate 23% higher than that of the remainder of the nation.[3] Although stroke death rates in North Carolina are declining faster than in the US overall, current state trends are significantly higher than the Healthy People 2020 target of 34.8 deaths per 100,000.[4]

Access to acute stroke care in western North Carolina is limited, with only one primary stroke center within an 18-county region. Rural western North Carolina counties are composed of a primarily elderly population located in a geographically challenging and remote setting, and they draw on limited health care resources to meet their health care needs. With limited access to health care, providing quality acute stroke care within rural communities is both a challenge and a priority. The purpose of this article is to describe one rural hospital's journey to The Joint Commission's Acute Stroke Ready Certification.

Background

Evidence shows that patients who sustain a stroke are more likely to have improved outcomes and fewer complications when hospitals use standardized care processes during a

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patient's admission and discharge from the hospital.[5] Key processes across the continuum of stroke care include[5]:

- Initial assessment, rapid transport, and early notification of hospitals by EMS personnel
- A system for emergent evaluation, diagnosis, and treatment in the emergency department that incorporates a stroke severity scale such as National Institute of Health Stroke Scale (NIHSS), limited laboratory tests, and stat brain imaging; smaller or rural facilities should treat to capacity and transport to a stroke center as quickly as possible
- Administration of acute stroke therapies including emergent intravenous thrombolytic therapy and/or endovascular thrombectomy to all eligible patients
- Appropriate poststroke care, preferably in a specialized stroke care unit
- Secondary prevention interventions and risk factor modification to include patient/family education about risk factors and prescription for lifestyle changes, medications, and other therapies to reduce ongoing risk

Hospitals that have organized a formal approach to the delivery of stroke care often pursue certification from accrediting agencies. The Joint Commission offers disease-specific certifications aimed at evaluating clinical programs across the continuum of care.[6] Originally launched in 2002, the certification of clinical programs aims to improve the quality of patient care through reducing variation in clinical processes and promoting a culture of excellence through objective assessment of evaluators. In collaboration with the American Heart and American Stroke Associations, The Joint Commission offers 3 levels of certification for hospitals seeking validation of their stroke program: Acute Stroke Ready Hospital, Primary Stroke Center, and Comprehensive Stroke Center.

Pursuit and maintenance of these certifications have been shown to improve patient outcomes. Although outcomes research has been limited to primary and comprehensive stroke centers, patients who were treated in stroke centers versus nondesignated hospitals had lower mortality rates and more frequent utilization of thrombolytic therapy in patients treated for acute ischemic stroke.[7] In a study of North Carolina

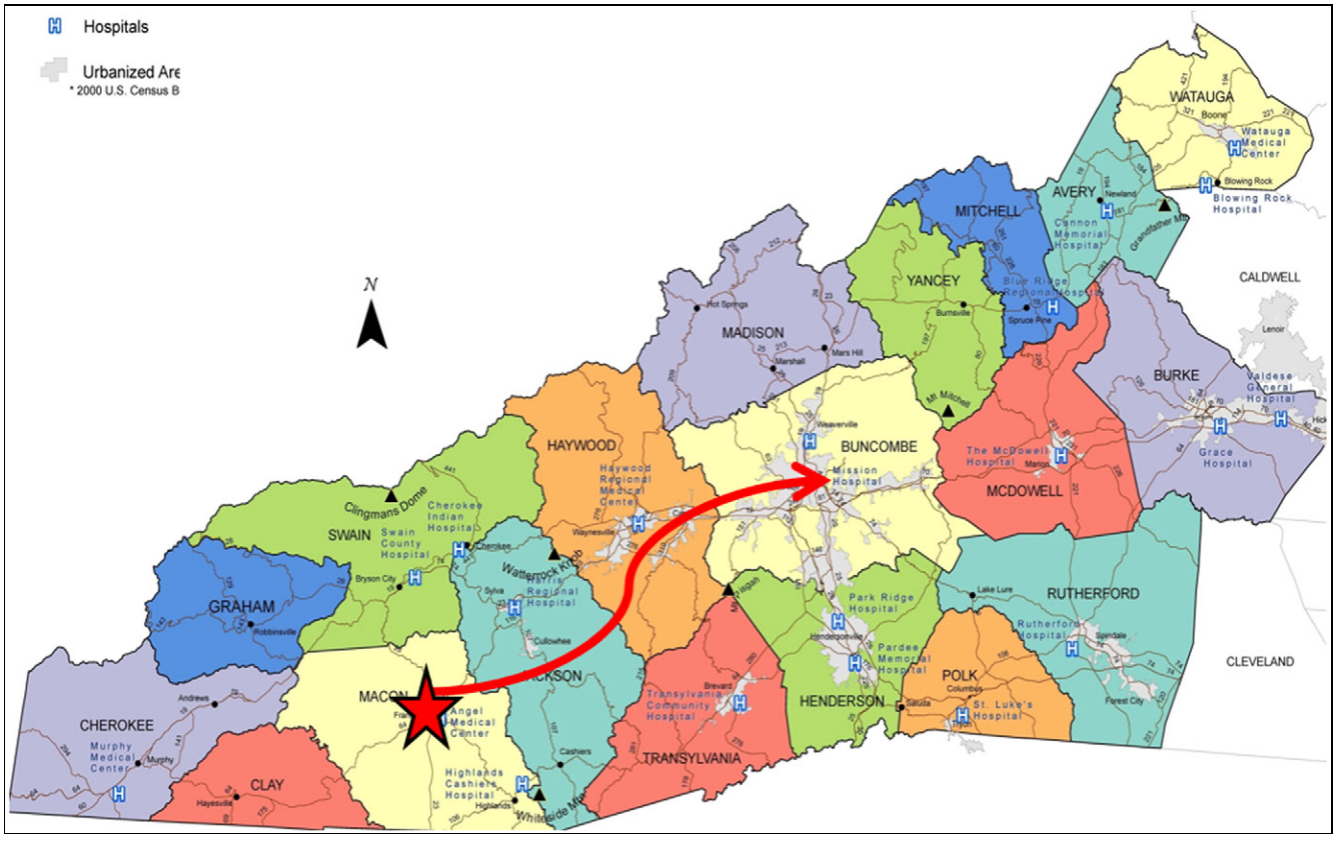

FIGURE 1

Eighteen-county coverage area in rural Western North Carolina, distance to closest Primary Stroke Center.

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