

Pursuing Stroke Center Certification: Are You Up to the Task?

By Stacey Morgan Lang

The number of Primary Stroke centers continues to grow across the country. Oftentimes, the decision to implement a formal stroke program is driven by local and regional market shifts, community need, and/or a desire on the part of the organization to build on existing program infrastructure in order to gain efficiencies across the system.

More recently, however, we find that hospitals are compelled to act as a result of regulatory changes at the state, local, and national levels that require patients with symptoms of stroke be transported *only* to an accredited stroke center. Irrespective of any legal mandate, many pre-hospital EMS providers are revising patient care protocols to include specific transfer criteria that require patients be taken only to those hospitals that have demonstrated a commitment to consistent care delivery via pursuit of formal stroke center accreditation.

Three specific examples of this national trend can be seen with recent happenings in Virginia, Missouri, and Illinois.

The state of **Missouri** has taken a proactive approach to the issue of timely treatment for patients suffering from stroke. In 2006, the Missouri Department of Health and Senior Services identified the lack of a “state-wide system to provide the right care, at the right place, at the right time.” State officials are working diligently to expand the existing *Time Critical Diagnosis System*, designed around the needs of the trauma patient, to include both stroke and ST elevation MIs, (STEMI). Such a measure would serve to facilitate the rapid evaluation and transport of patients with symptoms of stroke or STEMI only to facilities that are formally certified to care for them. The enforcement of these regulations has been outlined as a four-step approach, with full implementation likely to occur in mid-2010.

As an initial step, three work groups were established in 2008. One representing pre-hospital provider’s concerns, a second group charged with addressing hospitals needs and the impact on established care delivery models of the proposed system, and a third group intended to focus on the necessary rules and regulations. Since that time, much work has been done in developing the necessary infrastructure, care pathways and protocols, and quality improvement tracking mechanisms.

In 2008 in **Virginia**, the Emergency Medical Services Plan was amended with a statewide pre-hospital and inter-hospital *Stroke Triage Plan* designed to “promote rapid access for stroke patients to appropriate, organized stroke care through...generally-accepted criteria for stroke triage and appropriate transfer”. In a few months when this legislation becomes law, pre-hospital providers will be required to transport patients with symptoms of stroke only to hospitals that are certified as Stroke Centers.

In May, both the **Illinois** Senate and House voted unanimously to establish a network of specialist stroke centers in the state, allowing ambulances to bypass non-certified centers and transport patients to only those facilities that are certified. In the same way that Missouri has elected to build upon existing infrastructure, Illinois’s system for care of the stroke patient would be patterned after the way that emergency care is delivered for people with other types of substantial trauma.

It is essential that organizations across the country recognize the changes that are imminent to our care delivery system at the state, regional, and national levels. In fact, some degree of activity around Stroke care can be identified in essentially every state.

As more and more hospitals are affected by such trends, **being prepared for coming changes in stroke care delivery is the best strategy.** Hospitals should ACT NOW to proactively determine next steps related to certification as a Primary Stroke Center. This approach could evolve to be the new “norm” for hospitals that want to keep competitive edge and prevent market share losses.

According to the Brain Attack Coalition, hospitals pursuing Stroke Center Accreditation must have:

- Capability for 24/7 CT or MRI scans
- A written t-PA protocol in the emergency department
- Round-the-clock availability of an acute stroke team
- A Designated stroke center director
- Formal stroke training for ambulance personnel

These are just a few of the many recommendations. The focus on improving access to and timeliness of disease-specific, specialized care will no doubt impact the future success of a program—especially in terms of stroke, a condition which is gaining more and more attention as its incidence, severity, and impact on society becomes clearer.

In addition to the legislative mandates surrounding transport protocols for stroke patients that are being developed nationally, a fundamental change in the triaging, transport, and treatment of these patients is also occurring. As in Missouri and Illinois, in many states we see the development of stroke patient transport and treatment protocols closely mirroring those established years ago for the treatment of Trauma and STEMI patients.

In reality, the clinical requirements for all three of these patient populations require a remarkably similar approach in order to provide the best hope for optimal outcomes: fully functional patients. Rapid assessment in the field, communication with in-hospital providers prior to ambulance arrival, activation of a specialized and coordinated team of caregivers, rapid imaging, and established treatment protocols have all been shown to improve outcomes in each of these groups.

Corazon strongly believes that organizations that have invested the necessary time, energy, and resources to develop a top-quality cardiac program can benefit from these latest stroke treatment trends. By utilizing existing infrastructure, staff expertise, and the systems in place designed to afford rapid response and treatment for STEMI patients for example, hospitals can easily build upon past successes and so easily implement similar systems for the care of the stroke patient.

Research clearly demonstrates that a more organized and comprehensive approach to the care of the stroke patient improves clinical outcomes. It can be difficult, however, for many organizations to consider implementation of a Stroke Center either as an independent program or in tandem with a well established cardiovascular program. Concerns around availability of necessary capital, staff training and expertise, and the elevated acuity of the stroke patient are all factors to be considered. We find however, that forward thinking organizations recognize the importance of adapting to the changes in care delivery in advance of any legislative mandate. In fact, we find that those hospitals that implement a stroke program in concert with an existing cardiac program often realize several unexpected benefits.

- **Pre-Hospital Provider Relationships**

The introduction of a fully functioning Stroke Program allows a hospital to build on relationships with pre-hospital providers developed around a quality STEMI program and increase not only the types of patients transported to a facility, but also the acuity of those patients. By demonstrating clinical excellence in responding to the emergent needs of both stroke patients and STEMI patients, hospitals can foster greater confidence in pre-hospital providers and enjoy a resulting increase in all types of in-bound ambulance traffic.

- **Positive Impact on LOS**

A significant decrease in LOS for patients admitted with a diagnosis of stroke commonly occurs following the implementation of a formalized stroke program. Established treatment protocols and quality assurance can easily result in a decreased LOS of two days for many organizations. We encourage a thorough retrospective review of the projected financial impact to an organization for those patients admitted with a diagnosis of stroke. Not only will this exercise illustrate the gains to be made should LOS be successfully decreased, but perhaps more importantly, the information obtained will clearly identify the revenue loss that will occur if these patients are no longer transported to your facility.

- **Community Awareness**

The implementation of a formal stroke program can heighten a community's awareness of more than just the stroke initiative. When positioned properly, Stroke Center implementation can serve as a springboard for cross marketing of other related service lines within an organization. In addition to the cardiac program, women's health, diabetes, bariatrics, and vascular surgery can all be related to a stroke initiative and can serve to illustrate the full capabilities of any given hospital. Through the use of targeting marketing efforts, community education and awareness activities, and collaboration with existing community groups, hospitals can foster confidence in the services offered as well as an understanding of the comprehensive program capabilities that exist. All of these components are essential to building patient loyalty and support.

- **Physician Relationships**

The decision by an organization to implement a formal stroke program speaks volumes to its physician partners. Such an initiative not only demonstrates a commitment to quality patient care, it also illustrates a true awareness of patient need, current treatment trends, and national and regional legislative activity related to transporting these patients. After all, if stroke patients are bypassing your Emergency Room, they are also bypassing your physicians. Any erosion of patient volume, or the perception by a physician that a hospital cannot adequately

provide for all of a patient's needs, can irreparably damage even the most solid of referral patterns. In addition, it is important to remember that patients who present with stroke commonly require treatment for related disease conditions. Referrals to Cardiologists, Cardiac Surgeons, Internists, Endocrinologists, Neurosurgeons, and of course Neurologists are commonly required. The involvement of so many members of the medical staff can be invaluable in solidifying relationships as well as in maintaining the professional collaboration between physicians and administration, which is crucial to whole-hospital success.

We believe that cath lab professionals with the training, knowledge, and experience to provide care to the emergent cardiac patient are well positioned to assist with the implementation of a formal Stroke Program. While neuro-specific expertise will be required relative to the development of order sets, treatment protocols, patient assessment tools, and staff training, the leadership required for implementation of these protocols and pathways oftentimes fits well under the purview of the cath lab manager or cardiac service line leader.

As national laws and regional or state-specific rules change, all hospitals who treat stroke patients will feel the impact of patients coming to or bypassing their ED. And while pursuing Stroke Center accreditation or organizing a program around key protocols and processes is no easy task, **it's up to you to set goals and diligently seek to provide optimal care for acute stroke patients.** *Are you up to the task?*



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