

Arkansas Stroke Ready Hospital (ArSRH)
Re-designation Process Changes and Preparation Guide
Effective for Hospitals Re-designating Beginning January 2027

Introduction

The Arkansas Department of Health has revised the Arkansas Stroke Ready Hospital (ArSRH) re-designation requirements effective for hospitals re-designating beginning January 2027. The revisions align with CDC Paul Coverdell priorities, focus quality improvement efforts on key stroke-care processes, and simplify reporting by removing measures that no longer provide significant quality improvement value.

Key changes include the addition of **NIHSS Reported** and **LDL Documented** as required measures, while certain IV thrombolytic measures previously required for re-designation have been moved to reporting-only status. Core measures related to EMS pre-notification, stroke band identification, rapid CT imaging, timely thrombolytic treatment, EMS feedback, and community education remain required.

Hospitals are encouraged to review recent performance data, identify opportunities for improvement, and utilize the attached resources to prepare for the upcoming re-designation cycle.

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Questions? Contact Joanne LaBelle at Joanne.LaBelle@Arkansas.gov

Information for Stroke Coordinators

Preparing for the Arkansas Stroke Ready Re-designation Process

Arkansas Stroke Ready Hospitals (ArSRH) re-designation application revisions:

The Arkansas Stroke Ready Hospitals (ArSRH) re-designation application requirement have changed. In order to provide lead-time to stroke coordinators and staff, the changes will not be implemented until re-designation due **January 2027**. The process was changed to better align with CDC Paul Coverdell priorities, improve statewide adherence to key stroke care practices, and remove measures that no longer add quality improvement (QI) value. Core emergency stroke measures, including EMS pre-notification, stroke band use, rapid CT imaging for patients within 24-hours of last known well (LKW), timely IV thrombolytic therapy, EMS feedback, and community education, remain required because they reflect essential components of early recognition and acute treatment. Measures with consistently high statewide performance are being eliminated or shifted to reporting-only status, while NIHSS documentation and LDL documentation elevated to required measures to improve adherence and support defect-free stroke care. Two new Coverdell-aligned **Reporting** measures have changed to support ongoing QI without impacting re-designation eligibility. Please refer to **attachment #4** to better understand the reasons for the changes.

Steps to prepare for the Changes:

1. Assess current status: Run the most recent 12-months for each required and reporting measure (Attachment 1). Be sure to check “aggregate”. The result will be 1 numerator and 1 denominator for the 12-month period average.
2. If a measure is lower than 75%, this may be an area for QI.
 - a. Run a follow-up report. Uncheck “aggregate” to get a monthly report. Are all months below 75%? Is the more recent data adherence lower? Is adherence improving? These are questions that assist in guiding QI.
 - b. Are the most recent 3 months or more, meeting the 75% threshold? Has a recent change been made? This may indicate improvements have been made.
 - c. If measures need improvement. Attachments 2 – 3 outline QI strategies for the new Required Measures.
 - d. If QI assistance is needed, contact Joanne LaBelle at Joanne.LaBelle@Arkansas.gov.
3. If all required measures meet a minimum of 75%, the ArSRH re-designation data requirements are met. However, it may be time to increase the minimum adherence rate goal. The higher adherence can be achieved with QI.

Information for Stroke Coordinators

Preparing for the Arkansas Stroke Ready Re-designation Process

Understanding the CDC Coverdell Defect-free adherence:

1. Run the “AHA69 CDC Coverdell Defect Free” measure, found under the heading “Defect Free Measures”. Step-by-step directions are available upon request. If the overall adherence rate is at least 75%, the measure meets the requirement for ArSRH reporting requirement.
2. To measure the status of each of the 13 measures, there is a heading “Coverdell Measures”. Listed in this section are each of the 13 CDC Coverdell Defect Free measures. Step-by-step directions are available upon request.
3. Run all 13 measures, listed in the “Coverdell Measures” section. Identify the measure(s) not meeting a minimum of 75%. The only way to improve the overall CDC Coverdell Defect Free measure is improve all of the 13 measures not meeting expectations. If there are questions, do not hesitate to reach-out.
4. If adherence does not meet a minimum of 75%, begin QI interventions (note attachments #2 NIHSS Improvement Strategies; #3 LDL QI Strategy). Refer to the Measure Descriptions as a reference – Achievement, Quality and Reporting Measures and/or the coding instructions in the database “Library” section. Directions on finding these documents are available upon request. For QI strategies for other ArSRH Required Measures and Coverdell Measures, do not hesitate to contact Joanne LaBelle.
5. If assistance is needed:
 - a. Refer to the attachments for QI strategies:
 - NIHSS Reported – Attachment 2
 - LDL Documented - Attachment 3
 - b. Contact Joanne LaBelle for QI strategies for all other ArSRH Required and Reporting measures as well as CDC/COV Coverdell Measures.

Attachment #1
ArSRH RE-DESIGNATION MEASURE REQUIREMENTS:
Changes begins for hospitals re-designating beginning 01/2027
Section D. RE-DESIGNATION DATA METRICS

Hospital Name: _____

Date of Initial Designation: _____

Time Period Reported (most recent 12 months): _____

Num	Den	Rate (%)	Required Stroke Performance Measures - MUST MEET BENCHMARK	ADH Benchmark
		%	1. Pre-notification - % of cases of advanced notification by EMS for suspected stroke patients transported by EMS from scene.	75%
		%	2. Stroke Band ID - % of stroke patients for whom a stroke band identification number was recorded in the Stroke Registry.	75%
		%	3. Door to CT Time <=25 min - % of patients who received brain imaging within 25 minutes of arrival; filtered by 24-hours from last known well (LKW).	75%
		%	4. Time to Intravenous Thrombolytic Therapy – 60 minutes - % of acute ischemic stroke patients receiving therapy during the hospital stay who have a time from hospital arrival to initiation of thrombolytic therapy administration <= to 60 minutes .	75%
		%	5. NIHSS Reported - % of ischemic stroke and stroke not otherwise specified patients with a score reported for NIHSS.	75%
		%	6. LDL Documented	75%
Yes / No	Freq.	N/A	7. Feedback to EMS – Does the hospital provide feedback to local EMS on stroke patient final diagnosis and outcome? If yes, indicate frequency, i.e., weekly, monthly, etc. and how it is provided (spreadsheet, in-person, phone call etc.)	At least quarterly
Yes / No	Freq.	N/A	8. Community Education – Does the hospital currently perform community outreach events specific to increase stroke awareness and/or usage of 911 when stroke is suspected? If so, indicate the frequency.	At least monthly
Num	Den	Rate (%)	Reported Stroke Performance Measures - DOES NOT IMPACT RE-DESIGNATION	ADH Benchmark
		%	1. IV Thrombolytic Therapy Arrive by 3.5 Hour, Treat by 4.5 Hour - % of acute ischemic stroke patients who arrive at the hospital within 2 hours of time LKW and for whom IV thrombolytic was initiated at the hospital within 3 hours of time LKW.	75%
		%	2. Time to Intravenous Thrombolytic Therapy – 45 minutes - % of acute ischemic stroke patients receiving therapy during the hospital stay who have a time from hospital arrival to initiation of thrombolytic therapy administration <= to 45 minutes .	75%
		%	3. Door-in-Door-Out Times at First Hospital Prior to Transfer to Acute Therapy - % of confirmed stroke patients for whom <= 90 minutes was spent in the ED prior to transfer to a higher-level stroke center, e.g., PSC, CSC, etc. for time-critical therapy.	75%
		%	4. CDC/COV Defect-free Measure - Hospital meets all 13 eligible CDC stroke consensus measures.	75%

Attachment #2

Quality Improvement Measure NIHSS Reported

Patients Included: All ischemic stroke and not otherwise specified patients

Patient Care Issues:

Patients presenting within 3.5 hours of LKW, the NIHSS must be done as part of the initial assessment:

- ☐ MUST be done in the Emergency Department (ED) as part of the initial assessment. **NOTE:** If telemedicine is utilized, the initial NIHSS should be performed on video with the neurologist. Use that documentation. ENSURE the telemedicine consultation becomes a part of the patient record.
- ☐ A nurse or physician/APN/PA may conduct the NIHSS.

Patients presenting beyond 3.5 hours of LKW must be done within 48 hours: If not done in the ED:

- ☐ Add the NIHSS to the ischemic stroke patient's admission order set. If done in the ED, it can be marked as completed by the inpatient nurse. If not, add to the care plan.
- ☐ Conduct an NIHSS as part of the admission process. It can be done by a hospitalist, or RN, within 48 hours of arrival.
- ☐ The hospitalist/physician, completing the admission history and physical, may conduct the NIHSS as part of the physical. The NIHSS must be done within 48 hours of the patient's arrival. If possible, as an alternative, the admission nurse may request an ED nurse conduct the NIHSS on the unit, and within the request, document the expiration of the 48-hour time.
- ☐ If stroke patients are assessed by a neurologist within 48 hours, the neurologist can document the NIHSS.

Hints for improvement:

- ☐ A total score is the minimum standard. However, using the form and scoring each section is an assessment that can be used as comparison data.
- ☐ Filter the measure by 3.5 hours from LKW. The improvement process is different for patients arriving within or beyond 3.5 hours from LKW.
- ☐ Periodically offer in-service educational sessions with NIHSS instructions on use. Or incentivize the nursing and medical staff to take the online certification.
- ☐ Introduce the NIHSS in the ED, ICU and patient unit as the hospital standard for ischemic stroke and stroke not otherwise specified assessment.
- ☐ Conduct the NIHSS at discharge; as an objective tool for assessing outcome.

Possible documentation issues:

- ☐ The consultant report does not have the NIHSS documented. All consultants, or the ED physician/NP/PA assessing for IV-thrombolytic eligibility, **must consider the NIHSS** as part of the initial assessment. The RN may complete the assessment and provide the NIHSS to the physician.
- ☐ To ensure all the needed assessment information is in the chart as soon as possible, the ED RN, APN, PA or physician can document the total NIHSS score in the chart. For example, ".....the IDHI consultant, Dr. Johnson, conducted the NIHSS. The score reported is 5". If the consultant doesn't offer the NIHSS score, ask.....and then document.
- ☐ The consultant report must be a part of the patient record. The consultant report has valuable information that completes the patient's healthcare journey. Ensure the report is a **permanent part** of the patient record.
- ☐ Addendum notes, according to the hospital's policy, are acceptable.

Attachment #3
LDL Documented

LDL Documented

The ischemic stroke and TIA patients are required to have the LDL documented during his/her hospital admission. Note below for possible strategies to improve.

Possible in-patient QI Strategies:

- ☐ Add the LDL draw to the inpatient standard order set for ischemic stroke and TIA patients.
- ☐ If the LDL was done recently (within 6 months) and another is not necessary, the physician/NP/PA must record the date and result of the LDL.
- ☐ If the patient refuses testing, documentation of the refusal is needed.

Other strategies:

If the inpatient arena is **meeting the requirements** for documenting the LDL, there is no need to change the process. However, if it continues to be an unresolved issue, the blood may be draw in the Emergency Department (ED).

- ☐ Add the LDL draw to the ED standard order set. The LDL can be drawn when the patient presents to the ED. If unsure that the patient is having a TIA or stroke and prefer not to process the LDL at that time, have a draw and hold put on the specimen. Once there is more clarity, notify the laboratory staff to process or discard the specimen.
- ☐ It is acceptable to draw the LDL in the ED as evidence suggests that non-fasting lipid levels drawn in the first 48 hours after a major vascular event are reliable predictors of baseline lipid profiles, but after that time they may become unreliable.
- ☐ Refer to the Measure Descriptions for references – Quality Measures in the database Library.

Attachment #4
Reference Information for ArSRH Re-designation Process Changes

REQUIRED MEASURE CHANGES

Measures Removed:

Measures **removed** from the **Required** Measures:

IV thrombolytic therapy – Arrive by 2 hours; treat by 3 hours

- An important measure that has consistently high compliance statewide
- Hospitals show consistently high compliance statewide – All hospitals, re-designating, met, at least, the minimum performance for the past 2 years.
- Removing this measure keeps the focus on metrics in-need of improvement.

IV thrombolytic therapy – Arrive by 3.5 hours; treat by 4.5 hours

- An important measure that has consistently high compliance statewide
- Hospitals show consistently high compliance statewide – All hospitals, re-designating, met, at least, the minimum performance for the past 2 years.
- The measure is a CDC Coverdell defect-free care measure. Continued monitoring is important to confirm that adherence is maintained at a high level.
- Move to “Reporting Measures” to monitor for ongoing high adherence.

Measures Added:

Measures **added** to the **Required** Measures:

NIHSS Reported

- A key clinical measure used to assess stroke severity.
- Current data indicates an increase in adherence is needed.
- CDC/Coverdell Defect-free measure
- Consistent documentation and/or meeting care expectations, need to be improved. Oversight assists in improving clinical care and documentation through QI activities.

Steps to prepare:

- The NIHSS is required for all ischemic stroke patients, regardless of the time LKW.
- Run the NIHSS report – filter the report by “Arrival Date – LKW (minutes)”. Step-by-step directions are available upon request.
- If the overall adherence rate is at least 75%, the measure meets the requirement.
- If the overall adherence rate is less than 75%:

Attachment #4

Reference Information for ArSRH Re-designation Process Changes

- Identify if the lack of adherence is:
 - For all ischemic stroke patients regardless of LKW.
 - For ischemic stroke patients arriving within 3.5 hours of LKW at initial assessment.
 - For ischemic stroke patients beyond 3.5 hours of LKW, within 48 hours of presentation.
- Once the population, not meeting the NIHSS reported is identified, begin quality Improvement (QI) interventions (note attachment #1, NIHSS Reported strategies).
- Refer to the Measure Descriptions as a reference – Quality Measures in the database Library.

LDL Documented

- Adherence supports secondary stroke prevention
- CDC/Coverdell Defect-free measure
- Meeting care expectations needs to be improved. Oversight assists in improving clinical care through QI activities.

Steps to prepare:

- Run the LDL Documented report. Step-by-step directions are available upon request.
- If the overall adherence rate is at least 75%, the measure meets the requirement.
- If the overall adherence rate **does not** meet the minimum requirement:
 - Evidence suggests that non-fasting lipid levels drawn in the first 48 hours after a major vascular event are reliable predictors of baseline lipid profiles, but after that time they may become unreliable.
 - If the process is **not** working well in the in-patient setting, consider drawing the LDL as part of the Emergency Department (ED) initial blood draw. *
 - Refer to the Measure Descriptions as a reference – Quality Measures in the database Library.

***NOTE:** The current requirements for LDL have not changed. If the LDL documented process is working well in your organization, no changes are needed. If the process is not working well, and improvement is needed, drawing the LDL as part of the ED initial blood draw, may assist in meeting the requirements.

Attachment #4
Reference Information for ArSRH Re-designation Process Changes

REPORTED MEASURE CHANGES

Measures Removed:

Measures **removed** from the **Reporting** Measures:

Door to CT in <= 25 minutes

- Not the target patient population.
- The measure does not adjust for patients within 24 hours of LKW.
- The Door to CT in <= 25 minutes for patients within 24 hours of LKW is in the Required Measures.

Dysphagia Screen

- Although an important aspect of care, and overall adherence is not meeting expectations, other measures were added/maintained with lower adherence rates.
- Run the Dysphagia Screen measure. Step-by-step directions are available upon request.
- If adherence does not meet a minimum of 75%, begin QI interventions (contact J. LaBelle for assistance).
- Refer to the Measure Descriptions as a reference – Quality Measures in the database Library.

Measures Added:

Measures **added** to the **Reporting** Measures:

IV thrombolytic therapy – Arrive by 3.5 hours; treat by 4.5 hours

- Moved from Required Measures due to high performance.
- Monitor for sustained adherence rate.

Time to IV thrombolytic therapy in 45 minutes

- A key clinical measure monitoring the timely administration of IV thrombolytics. The timely and safe administration of the medication increases the effectiveness of the treatment and decreases the potential for complications and/or decreases its effectiveness.
- Current data indicates an increase in adherence is needed.
- CDC/Coverdell Defect-free measure.

Steps to prepare:

Attachment #4
Reference Information for ArSRH Re-designation Process Changes

- Run the IV thrombolytic therapy in 45 minutes report – filter the report by “Mode of Arrival”. Step-by-step directions are available upon request.
- If the overall adherence rate is at least 75%, the measure meets the requirement.
- It is important to have a timely and safe administration. Filtering the data by mode of arrival (EMS, private vehicle (PoV)) is critical to identify the areas where improvement is needed. The processes for patients arriving by EMS and PoV are different. Understanding the rate per EMS and PoV arrivals assists in targeting the appropriate changes.
- If adherence does not meet a minimum of 75%, begin QI interventions (note attachments #4 Patient-related Delay documentation; #5 IV thrombolytic therapy in 60 and 45 minutes and #6 Phase 3 Time Targets).
- Refer to the Measure Descriptions as a reference – Reporting Measures in the database Library.

CDC Coverdell Defect-free Measure

- The CDC Coverdell Defect-free measure is used by the Center for Disease Control and Prevention (CDC), American Heart Association (AHA), the Arkansas Department of Health (ADH) as well as nationally accrediting bodies. It is used as a summary of selected acute, inpatient and discharge aspects of care. There are 13 measures included in the CDC Coverdell Defect-free measure. It is used as a measure of success, tracking improvement in the care of the stroke patient for each hospital, county, state, and the country.
- The element measures each patient’s care. The denominator is “patients”. Not all patients are “appropriate” for all 13 measures; and the database, based on the patient's history, presentation and assessment, pulls patients in or out of the 13 measures. If a patient receives the care, he/she is appropriate for, related to the 13 processes, the result is 1 out of 1 patient (1/1) received appropriate stroke care. If one aspect of care is missing, the result is 0 patient out of 1 patient (0/1) received the appropriate care. It is an all or nothing result; either the patient gets all the care he/she is appropriate for (1/1) or if just one is missed, it is (0/1).
- To improve the CDC/COV Defect-free Measure, improve all measures not meeting expectations.