Thrombolysis With Intravenous Tissue Plasminogen Activator Predicts a Favorable Discharge Disposition in Patients With Acute Ischemic Stroke

Nneka L. Ifejika-Jones, MD, MPH; Nusrat Harun, MSPH; Nareesa A. Mohammed-Rajput, MD, MPH; Elizabeth A. Noser, MD; James C. Grotta, MD

Background and Purpose—Acute ischemic stroke patients who receive recombinant tissue plasminogen activator (rt-PA) within 3 hours of symptom onset are 30% more likely to have minimal to no disability at 3 months. During hospitalization, short-term disability is subjectively measured by discharge disposition, whether to home, inpatient rehabilitation, a skilled nursing facility, or subacute care. There are no studies assessing the role of recombinant tissue plasminogen activator use as a predictor of poststroke discharge disposition.

Methods—We conducted a retrospective analysis of all patients with ischemic stroke who presented within the original three hour window for intravenous thrombolysis, and who were admitted to the University of Texas Houston Medical School Stroke Service at Memorial Hermann Hospital - Texas Medical Center between January 2004 and October 2009. Baseline demographics and National Institute of Health Stroke Scale score were collected. Cerebrovascular disease risk factors were used for risk stratification in the multivariate regression.

Results—Out of 2225 patients with acute ischemic stroke, 1019 were discharged to home, 719 to inpatient rehabilitation, 371 to a skilled nursing facility and 116 to subacute care. Patients who received recombinant tissue plasminogen activator therapy were more likely to be discharged home compared to the other levels of care ($P<0.0001$; OR, 1.945; 95% CI, 1.538 to 2.459). Considering post-acute inpatient rehabilitation versus skilled nursing facility/subacute care and disposition at a skilled nursing facility versus subacute care, there were no differences in disposition between patients who received recombinant tissue plasminogen activator therapy. Inpatient Rehabilitation versus Skilled Nursing Facility or Subacute Care ($P = 0.123$); Skilled Nursing Facility versus Subacute Care ($P = 0.605$).

Conclusions—Patients who receive intravenous recombinant tissue plasminogen activator as treatment for acute ischemic stroke are more likely to be discharged directly home after hospitalization. This study is limited by its retrospective nature and the undetermined role of psychosocial factors related to discharge. (Stroke. 2011;42:700-704.)

Key Words: outcomes ■ rehabilitation ■ stroke recovery ■ thrombolysis

Cerebrovascular disease is the leading cause of long-term disability in the United States, increasing costs of postacute care and caregiver burden.$^{1,2}$ Outcomes research is critically important in this population, particularly related to poststroke discharge disposition. The discharge level of care after an acute stroke is directly related to clinical outcomes, including functional status, activity tolerance, and medical acuity.

Rehabilitation medicine is a relatively young and diverse field that extends from the first days of inpatient care to years of chronic treatment in a range of settings.$^3$ The goal of stroke rehabilitation is to improve recovery in the weeks after a stroke and to decrease disability during the years that follow. For an inpatient rehabilitation facility (IRF) to be compensated by Medicare, a minimum of 60% of the facility’s total inpatient population must meet 1 of 13 medical conditions. The 13 medical conditions that qualify for the 60% rule are stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, brain injury, fracture of femur (hip), burns and neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson disease.$^4$

An incarnation of the compliance rule has been part of the IRF payment criteria since the implementation of the Inpatient Prospective Payment System in 1983. Its purpose is to ensure that IRFs are primarily providing rehabilitation services to patients who cannot be served in other, less intensive rehabilitation settings such as a skilled nursing facility (SNF). Over the past 10 years, this rule has undergone significant alterations. In
likely to have minimal or no disability at 3 months.10 During the transition period was instituted to gradually increase the compliance rate from 50% in 2004% to 75% by 2007. However, in 2007, Congress passed the Medicare, Medicaid, and SCHIP Extension Act, which set the IRF compliance rule at no more than 60% retroactive to cost-reporting periods beginning on or after July 1st. The influence of the compliance rule has been a longstanding source of concern for rehabilitation units, as Medicare accounts for approximately 70% of IRF cases with an estimated 5.6 billion dollars paid to IRFs annually.6

To qualify for admission to an IRF, patients must require close medical supervision by a rehabilitation physician, 24-hour nursing care, and a coordinated multidisciplinary rehabilitation program consisting of a combination of physical therapy, occupational therapy, speech and language pathology, nursing, case management, and social work. In addition, patients must be able to participate in an intense rehabilitation regimen for a duration of a minimum of 3 hours daily and be expected to achieve significant practical improvement over a short period of time.4

Patients receiving care in a SNF traditionally exhibit decreased activity tolerance; therefore, they would not be able to participate in 3 hours of therapy daily required for inpatient rehabilitation. A patient whose SNF stay is based solely on the need for rehabilitation services would meet the “daily basis” requirement, they would receive a combination of physical, occupational, and speech therapy at least 5 days a week.7

Subacute care is a transitional level of treatment for medically stable patients who no longer require daily diagnostic/invasive care. Also known as long-term acute care, the patients at this level require 24-hour access to services available in an acute care hospital. In addition, the patient may require tracheotomy care and/or mechanical ventilation plus any 1 of 6 treatment procedures, including tube feeding, wound care, continuous intravenous therapy (hydration or antibiotic), frequent nebulizer treatments, total parental nutrition, and inpatient physical, occupational, or speech therapy.8

Patients with stroke admitted to subacute care predominantly have severe disability due to large infarcts.9

Intermediate care facilities provide treatment for individuals who are disabled, mentally handicapped, or chronically ill.9 To qualify for intermediate care services, a patient must have a medical condition that requires observation on an intermittent basis to prevent deterioration. Compared with the previously mentioned levels of care, neither skilled nursing nor therapy services are required in intermediate care facilities. Patients in intermediate care facilities also exhibit more independence with basic activities of daily living than those served by inpatient rehabilitation, SNFs, or subacute care.10

The National Institute of Neurological Disorders and Stroke rtPA Stroke Study investigators have demonstrated that patients with acute ischemic stroke receiving intravenous tissue plasminogen activator within 3 hours of symptom onset are 30% more likely to have minimal or no disability at 3 months.10 During hospitalization, short-term disability and functional status are subjectively measured by discharge disposition, whether to home, inpatient rehabilitation (IR), a SNF, or subacute care (Sub). There are no studies assessing the role of recombinant intravenous tissue plasminogen activator (rtPA) treatment for acute ischemic stroke as a predictor of functional status evidenced by poststroke discharge disposition.

Table 1. Demographics of Acute Ischemic Stroke Patients ≥ Intravenous rtPA Therapy

<table>
<thead>
<tr>
<th>rtPA</th>
<th>No rtPA</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years, mean±SD</td>
<td>65.32±15.02</td>
<td>64.12±14.83</td>
</tr>
<tr>
<td>NIHSS on arrival, median (IQR)</td>
<td>12 (6–18)</td>
<td>5 (2–12)</td>
</tr>
<tr>
<td>Gender, % male</td>
<td>53.18</td>
<td>51.35</td>
</tr>
<tr>
<td>Race, %</td>
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<tr>
<td>Black</td>
<td>30</td>
<td>36.5</td>
</tr>
<tr>
<td>Hispanic</td>
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<td>13.5</td>
</tr>
<tr>
<td>White</td>
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<td>48</td>
</tr>
<tr>
<td>Other</td>
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<td>2</td>
</tr>
<tr>
<td>Death, % (no.)</td>
<td>12 (104)</td>
<td>5.4 (102)</td>
</tr>
<tr>
<td>Alternate disposition, % (no.)</td>
<td>43 (314)</td>
<td>46 (792)</td>
</tr>
<tr>
<td>Home for Custodial/Hospice Care</td>
<td>3.35 (25)</td>
<td>2.40 (45)</td>
</tr>
<tr>
<td>Disposition, % (no.)</td>
<td>0.2699</td>
<td></td>
</tr>
<tr>
<td>Home ≤ outpatient therapy</td>
<td>33 (239)</td>
<td>32 (551)</td>
</tr>
<tr>
<td>SNF</td>
<td>17 (127)</td>
<td>17 (292)</td>
</tr>
<tr>
<td>Sub</td>
<td>7 (52)</td>
<td>5 (92)</td>
</tr>
</tbody>
</table>

IQR indicates interquartile range.

Subjects and Methods

We conducted a retrospective analysis a prospectively collected quality assured database of all patients with ischemic stroke admitted to the University of Texas Houston Medical School Stroke Service at Memorial Hermann Hospital Texas Medical Center between January 2004 and October 2009 with discharge disposition of home, IR, a SNF, or Sub. Memorial Hermann Hospital Texas Medical Center is a tertiary care center with an in-hospital inpatient rehabilitation unit; all patients who meet admission criteria are accepted, regardless of insurance type or ability to pay. Patients were included if they presented within the original 3-hour window for intravenous thrombosis.

Baseline demographics, including age, gender, ethnicity, and National Institutes of Health Stroke Scale (NIHSS) score on arrival, were collected (Table 1). All patients had frequent vital sign monitoring including an electrocardiogram and 24 hours of telemetry. Cardiac and cerebrovascular imaging, lipid and glucose levels were obtained as part of routine practice; all of which were used in the multivariate model for risk stratification (Table 2). Medical records were reviewed to determine presence of comorbidities that can affect outcome. Modified Rankin Scale score was obtained at discharge for all patients.

Exclusion criteria were diagnosis of intracranial hemorrhage, transient ischemic attack, and alternate disposition (discharge to other service or left against medical advice). Discharge to home for custodial/hospice care and death were included in the analysis to determine whether there was increased morbidity or mortality in the rtPA versus the non-rtPA group. Cerebrovascular disease risk factors were used for risk assessment and stratification; the presence of multiple medical comorbidities increase the likelihood of poststroke discharge disposition.
The primary independent variable is the use of rtPA in acute ischemic stroke; the primary dependent variable is functional status. We used discharge disposition as a proxy for functional status. The levels of discharge disposition were matched in paired groupings (Home vs. Other Level of Care, Inpatient Rehabilitation vs. Skilled Nursing Facility or Subacute Care and Skilled Nursing Facility vs. Subacute Care). The NIHSS is an excellent predictor of clinical outcomes and hospital discharge disposition.\(^1\) We used NIHSS on arrival as a continuous variable in the multivariate regression; low NIHSS in patients with acute ischemic stroke predicts post stroke disposition to a level of care suggestive of improved functional status.

Statistical Analyses were performed using SAS 9.2 (Cary, NC). Continuous variables were reported as mean ± SD when the distribution was normal and median with range for nonnormal distributions. The NIHSS score was reported as the median with the interquartile range. Categorical variables were analyzed using \(\chi^2\) and Fisher exact tests when appropriate. We performed \(t\) test to assess the differences in means; Wilcoxon test was used to evaluate for differences in medians. We used logistic regression to determine differences in post-stroke disposition adjusting for cerebrovascular disease risk factors among patients who received rtPA for acute ischemic stroke.

### Results

Out of our study sample size of 2459 patients with discharge disposition to home, inpatient rehabilitation, skilled nursing facility or subacute care, nine percent of the patients were excluded secondary to missing data for the explanatory variable (Table 1). This has been attributed to the merging of data fields from earlier forms of the University of Texas Houston Medical School Stroke Registry, a common quandary with outcomes studies. During secondary analysis, we discovered the missing fields were evenly distributed uniformly between primary independent and dependent variables. The administration of IV rt-PA for acute ischemic stroke is correlated with increased mortality (12% vs. 5.4% in the no rt-PA group; \(P = 0.0001\); Table 1); there were no statistically significant differences in the likelihood of discharge to home for hospice care (2.5% vs. 4% in the no rt-PA group; \(P = 0.1638\); Table 1). A total of 2756 patients were included in the independent risk stratification analyses (Tables 2 and 3); this was narrowed by 0.65% during assessment of demographic information due to missing variables for ethnicity.

### Discharge Disposition to Home Versus Other Level of Care (IR, SNF, or Sub)

Of the remaining 2225 patients, 1019 were discharged home, 1206 to IR, a SNF, or Sub. After accounting for all effects in the multivariate regression, patients who received rtPA for acute ischemic stroke were more likely to be discharged home (\(P < 0.0001\); OR, 1.945; 95% CI, 1.538 to 2.459; Table 4). Both increased age (\(P < 0.0001\); OR, 0.967; 95% CI, 0.960 to 0.974) and NIHSS on arrival (\(P < 0.0001\); OR, 0.822; 95% CI, 0.805 to 0.840) were associated with discharge disposition to another level of care.

The odds ratio was higher for acute ischemic stroke patients treated with IV rt-PA in relation to discharge disposition than several cerebrovascular disease risk factors, including cardiovascular disease (\(P = 0.187\); OR, 1.156; 95% CI, 0.932 to 1.434), diabetes mellitus (\(P = 0.041\); OR, 0.803; 95% CI, 0.650 to 0.991), hypertension (\(P = 0.177\); OR, 0.850; 95% CI, 0.671 to 1.076), hyperlipidemia (\(P = 0.016\); OR, 0.774; 95% CI, 0.628 to 0.954), and history of stroke (\(P = 0.023\); OR, 1.311; 95% CI, 1.037 to 1.658).

### Discharge Disposition to IR Versus Other Level of Care (SNF or Sub)

Of the remaining 1206 patients with acute ischemic stroke, 719 patients were discharged to acute IR and 487 to either a SNF or Sub. After accounting for all effects in the multivariate regression, there were no statistically significant differences in disposition between patients who received and did not receive rtPA (\(P = 0.123\); OR, 1.255; 95% CI, 0.940 to 1.675; Table 5).
Table 5. Effects of Independent Variables plus Intravenous rt-PA Therapy – Discharge Disposition to Inpatient Rehabilitation vs. Skilled Nursing Facility or Subacute Care

<table>
<thead>
<tr>
<th>Variable</th>
<th>P</th>
<th>OR</th>
<th>95% CI, Lower</th>
<th>95% CI, Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>rtPA</td>
<td>0.123</td>
<td>1.255</td>
<td>0.940</td>
<td>1.675</td>
</tr>
<tr>
<td>NIHSS on arrival</td>
<td>&lt;0.0001</td>
<td>0.913</td>
<td>0.896</td>
<td>0.930</td>
</tr>
<tr>
<td>Age</td>
<td>0.006</td>
<td>1.026</td>
<td>1.045</td>
<td>1.007</td>
</tr>
<tr>
<td>CV</td>
<td>0.031</td>
<td>0.741</td>
<td>0.564</td>
<td>0.973</td>
</tr>
<tr>
<td>DM</td>
<td>0.131</td>
<td>0.806</td>
<td>0.608</td>
<td>1.067</td>
</tr>
<tr>
<td>HTN</td>
<td>0.172</td>
<td>1.257</td>
<td>0.905</td>
<td>1.744</td>
</tr>
<tr>
<td>HLD</td>
<td>0.251</td>
<td>1.184</td>
<td>0.888</td>
<td>1.579</td>
</tr>
<tr>
<td>Hx stroke</td>
<td>&lt;0.0001</td>
<td>2.424</td>
<td>1.784</td>
<td>3.293</td>
</tr>
</tbody>
</table>

CV indicates cardiovascular; DM, diabetes mellitus; HTN, hypertension; HLD, hyperlipidemia; Hx, history of.

The presence of advanced age predicted discharge to a SNF or subacute level of care (P<0.0001; OR, 0.948; 95% CI, 0.938 to 0.958). Unlike the first analysis, cardiovascular disease predicted discharge to a SNF or Sub, which corroborates the importance of activity tolerance when determining poststroke discharge disposition (P=0.031; OR, 0.741; 95% CI, 0.564 to 0.973).

Increased NIHSS on arrival predicts discharge disposition to a SNF or Sub independent of rtPA use (P<0.0001; OR, 0.913; 95% CI, 0.896 to 0.930). History of stroke is also predictive of discharge disposition to either a SNF or Sub; these patients are more likely to have a physical impairment at baseline (P<0.0001; OR, 2.424; 95% CI, 1.784 to 3.293). There were no significant differences in disposition to IR versus a SNF or Sub for patients with diabetes mellitus, hypertension, or hyperlipidemia (Table 5).

Discussion

To our knowledge, this study is the first to provide a direct link between the administration of intravenous rtPA for treatment of patients with acute ischemic stroke and improved short-term outcomes evidenced by discharge disposition to home versus another level of care. The association between this short-term outcome and long-term disability has not been studied; this will be the focus of future research. Patients who received rt-PA tended to have higher NIHSS on arrival than the non-treatment group, lower age, normal cholesterol values and no prior history of stroke.

The variability of the 60% rule during the study time period has a potential confounding effect on patients admitted to IRFs. Although Congress passed the Medicare, Medicaid, and SCHIP Extension Act in 2007, it only applied to reimbursement of payments to IRFs; it has no bearing on our analyses and the appropriateness of the discharge level of care during that time period. Future studies will further be impacted by the new Center for Medicare and Medicaid Services 2010 IRF coverage requirements. The Center for Medicare and Medicaid Services 2010 guidelines are an effort to determine whether individual IRF claims are reasonable and necessary. The new coverage requirements document whether the patient is medically stable to benefit from IR admission, specify the need for coordinated multidisciplinary rehabilitation care, and outline benefit from the intensity of treatment provided in an IRF. The impact of these new guidelines on IRF admissions is yet to be seen, and it will be the subject of future studies.

Consistent with previous studies, we found that low NIHSS on arrival has the strongest correlation with discharge to home; however, the conclusion that rtPA use has a stronger correlation to favorable discharge disposition than several cerebrovascular disease risk factors has a significant impact on the role of rtPA as a prognostic indicator in this population. Our analysis is based on data collected within the traditional 3-hour window of intravenous thrombolysis; future studies will extrapolate the data to 4.5 hours.

There are considerable barriers to care in the IR, SNF, and Sub groups. Although organized stroke care with timely multidisciplinary IR is associated with improved outcomes, many patients are unable to access postacute rehabilitation services secondary to lack of insurance or underinsurance. Use and accessibility of postacute services vary with age, race/ethnicity, and geographic region. Advanced age can be used as both an outcome predictor and a screening tool for Medicare eligibility in populations that may otherwise be uninsured. Postacute care facilities predominantly serve patients who have the financial means to pay for care, whether through insurance or independently. This study was conducted at a tertiary care center with an...
in-hospital IRF; therefore, all patients who meet criteria for admission are accepted. The results of this study may not be extrapolated to centers in which patients have to undergo financial screening as a part of eligibility.

Disposition after postacute hospitalization is a factor in admission to each prospective level of care. If a candidate is IR-appropriate but needs supervision for safety, cognitive impairment, or physical limitations, it is recommended that a caregiver be identified before transfer of care is completed. These patients may be transferred to a SNF, which traditionally has a longer length of stay, until a caregiver becomes available. It is estimated that 25% to 74% of stroke survivors require assistance with activities of daily living from informal caregivers, often family members. Although the physical, psychological, emotional, and social consequences of caregiving and its economic benefit to society are well recognized, caregivers' needs are often given low priority in stroke management and many caregivers feel inadequately trained, poorly informed, and dissatisfied with the level of support provided after discharge. A key determinant of whether a patient can be discharged home is the competency and physical ability of the caregiver, which is unrelated to the status of the patient. These patients may be appropriate for discharge home, but are instead admitted to an IRF or a SNF if their caregiver is unable to meet their functional needs.

We cannot comment on patients with ischemic stroke who transition to another level of care after IR. There is a percentage of patients who were determined to be appropriate for IR that are unable to tolerate 3 hours of therapy daily; therefore, they are transferred to a SNF. In the future, we will track the disposition of patients with acute stroke after IR to capture these outliers.

This analysis is retrospective; we endeavored to stratify the data for age, stroke severity, and known risk factors that suggest worse outcomes. In addition, the use of retrospective data makes it difficult to collect missing variables, which accounted for 9% loss of data in this study. There is potential confounding related to whether intravenous rtPA truly predicts better outcomes or are there other unknown causes. This possibility is best addressed with a prospective observational study of this patient group.

In summary, patients with acute ischemic stroke who received intravenous rtPA within the traditional 3-hour window were more likely to be discharged home and not require postacute hospitalization. Improvements in treatment of acute stroke frequently bring net health expenditure savings by reducing racial/ethnic disparities in access to care. Health Serv Res. 2005;38:809–829.

Inpatient Reimbursement: Classification Criteria for Inpatient Rehabilitation Facilities (IRFs).

Hargraves JL, Hadley J. The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care. Health Serv Res. 2005;38:809–829.


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Disclosures

None.

References


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http://stroke.ahajournals.org/content/42/3/700

Data Supplement (unedited) at:

http://stroke.ahajournals.org/content/suppl/2012/02/28/STROKEAHA.111.604108.DC1
Original Contributions

静脉用组织纤溶酶原激活物溶栓预示急性缺血性卒中患者出院时的状况良好

Thrombolysis With Intravenous Tissue Plasminogen Activator Predicts a Favorable Discharge Disposition in Patients With Acute Ischemic Stroke

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背景与目的：在症状发生3小时内接受重组型组织纤溶酶原激活物(rt-PA)溶栓的急性缺血性卒中患者有30%的机会在3个月时无或有很轻的功能障碍。在住院期间，短期功能障碍是由出院时的状况主观进行判断的，决定是直接回家、住院康复、转至专业护理机构或接受亚急性期治疗。目前尚无研究评估rt-PA溶栓在预测卒中后出院安置中的作用。

方法：我们对2004年1月至2009年10月间在德克萨斯大学休斯顿医学院的赫尔曼纪念医院-德州医学中心的卒中中心收治的发病3小时溶栓治疗时间窗内的所有缺血性卒中患者进行了回顾性分析，收集人口统计学基线资料及NIHSS评分。脑血管疾病的危险因素在多元回归分析中用于危险分层。

结果：总共2225例急性缺血性卒中患者，其中1019例出院回家，719例继续住院康复，371例转至专业的护理机构及116例进行亚急性治疗。与对照组相比，接受rt-PA溶栓治疗的患者出院后直接回家的可能性要高于出院时的其他级别的照料（P<0.0001；OR，1.945；95% CI，1.538-2.459）。rt-PA溶栓治疗的患者与未溶栓患者之间，急性期后继续住院康复与转至专业的护理机构/接受亚急性治疗之比无显著差异（P=0.123）；转至专业的护理机构与进行亚急性治疗之比亦无显著差异（P=0.605）。

结论：接受rt-PA溶栓治疗的急性缺血性卒中患者在经住院治疗后更有可能直接回家。研究的局限性在于回顾性研究且未明确心理社会因素对出院的影响。

关键词：结局，康复，卒中恢复，溶栓

Stroke. 2011;42:700-704. 上海交通大学医学院附属仁济医院神经科 宋叶平 译 李焰生 校
较大幅度的调整。2002年，医疗保险(Medicare)中心和医疗补助服务(Medicaid Service)通过财政中介延迟执行规定的75%，主要是担心该规则并未在全国范围内统一实行[9]。2004年，医疗保险和医疗补助服务中心再次重申了规则，并将适用标准扩大到13个病种的符合情况。另外，设立3年的过渡期以逐渐提高适用比例，从2004年的50%增加到2007年的75%。然而，2007年，国会通过了医疗保险、医疗补助及SCHIP扩大法案，设置了IRF适用规则为不超过追溯自7月1日开始的费用报告期的60%。适用规则的影响是康复单位长期担忧的一个原因，因为医疗保险(Medicare)要为每年总计约56亿美元的IRF患者支付其中的70%[6]。

rt-PA静脉溶栓的急性缺血性卒中患者，30%者更有可能在3个月时无或仅有轻微的功能障碍[10]。在住院期间，短期功能障碍和功能状态的判断是根据出院时的去向而主观评估，去向包括直接回家、住院康复、转至专业的护理机构或接受亚急性照料。目前尚无研究评估急性缺血性卒中rt-PA静脉溶栓在预测卒中后出院去向所提示的功能状态中的作用。对象与方法

我们对前瞻性收集的可靠的缺血性卒中资料库进行回顾性分析，该库有2004年1月至2009年10月间在德克萨斯大学休斯顿医学院的赫尔曼纪念医院-德州医学中心的卒中中心收治的所有缺血性卒中患者的出院后去向，包括直接回家、住院康复(IR)、SNF、亚急性照料(Sub)。赫尔曼纪念医院-德州医学中心是一个具有院内康复单元的三级医疗中心；接收满足入院标准的所有患者，不考虑其保险类型或支付能力。纳入在发病3小时内溶栓治疗的卒中患者。

表1是否rt-PA静脉溶栓的急性缺血性卒中患者的人口学资料

<table>
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<tr>
<th></th>
<th>rt-PA (865)</th>
<th>无rt-PA (1873)</th>
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<td>年龄，岁，均数±标准差</td>
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<td>64.12±14.83</td>
<td>0.6648</td>
</tr>
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<td>就诊时NIHSS评分</td>
<td>12 (6-18)</td>
<td>5 (2-12)</td>
<td>&lt;0.0001</td>
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<td>性别，男%</td>
<td>53.18</td>
<td>51.35</td>
<td>0.3725</td>
</tr>
<tr>
<td>种族，%</td>
<td></td>
<td></td>
<td>0.0059</td>
</tr>
<tr>
<td>黑人</td>
<td>30</td>
<td>36.5</td>
<td></td>
</tr>
<tr>
<td>西班牙裔</td>
<td>13</td>
<td>13.5</td>
<td></td>
</tr>
<tr>
<td>白人</td>
<td>55</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>其它</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>死亡，% (例数)</td>
<td>12 (104)</td>
<td>5.4 (102)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>不同安置去向，% (例数)</td>
<td>3.35 (25)</td>
<td>2.40 (45)</td>
<td>0.1638</td>
</tr>
<tr>
<td>去向 (%)</td>
<td></td>
<td></td>
<td>0.2699</td>
</tr>
<tr>
<td>回家 ± 门诊</td>
<td>43 (314)</td>
<td>46 (792)</td>
<td></td>
</tr>
<tr>
<td>IRF</td>
<td>33 (239)</td>
<td>32 (551)</td>
<td></td>
</tr>
<tr>
<td>SNF</td>
<td>17 (127)</td>
<td>17 (292)</td>
<td></td>
</tr>
<tr>
<td>Sub</td>
<td>7 (52)</td>
<td>5 (92)</td>
<td></td>
</tr>
</tbody>
</table>

IQR指的是四分位间距。
**Stroke**  March 2011

## Table 2 用于危险分层的自变量

<table>
<thead>
<tr>
<th>变量</th>
<th>定义</th>
</tr>
</thead>
<tbody>
<tr>
<td>心血管疾病</td>
<td>房颤, 充血性心力衰竭, 冠心病, 心梗史, 周围血管病</td>
</tr>
<tr>
<td>糖尿病</td>
<td>糖尿病史或就诊时血糖 &gt; 200</td>
</tr>
<tr>
<td>高血压</td>
<td>高血压病史或就诊时血压升高</td>
</tr>
<tr>
<td>高脂血症</td>
<td>高脂血症史或就诊时总胆固醇 &gt; 200</td>
</tr>
<tr>
<td>卒中史</td>
<td>脑血管事件病史 (短暂性脑缺血发作, 急性脑梗, 脑出血, 硬膜外血肿, 硬膜下血肿, 蛛网膜下腔出血 )</td>
</tr>
</tbody>
</table>

Rankin 评分 (mRS)。

排除标准为颅内出血、短暂性脑缺血发作和出院后其他去向（出院后至其他服务中心或者不能遵医嘱）。出院后在家或在临终关怀医院接受临终关怀及死亡的患者亦纳入分析，以确定是否 rtPA 组的发病率或死亡率较非 rtPA 组增加。脑血管病的危险因素被用于风险评估和分层。存在多种合并症会增加卒中后死亡及出院后转入体现患者功能状态较差的照料单位的似然值（表 3）。

主要自变量是急性缺血性卒中患者 rtPA，主要因变量是患者的功能状态。我们用出院后的去向体现患者的功能状态。对出院后去向级别进行配对分组（直接回家对其他水平的照料，住院康复对转至专业的护理机构或亚急性照料，转至专业的护理机构对亚急性照料）。NIHSS 评分是很好的临床结局和出院后去向的预测 [11,12]。在多变量回归分析中，我们用就诊时 NIHSS 评分作为连续变量。急性缺血性卒中患者的 NIHSS 评分低预示卒中后转入体现功能状态较好的照料单位。

统计分析采用 SAS 9.2 (Cary, NC)。连续变量呈正态分布以均数 ± 标准差表示，呈非正态分布以中位数和范围表示。NIHSS 评分用四分位距的中位数表示。在适当的时候分类变量用 χ² 检验和 Fisher 确切检验进行分析。我们用 t 检验评估均数之间的差异，用 Wilcoxon 检验评估中位数之间的差异。在校正接受 rtPA 溶栓治疗急性缺血性卒中患者的脑血管病的危险因素后，我们用 logistic 回归分析来明确卒中后去向的差异性。

### 结果

本研究共有 2459 例患者出院后直接回家、住院康复、转至专业的护理机构或接受亚急性照料，9% 的患者因作为解释变量的数据丢失而被剔除（表 1）。这是德克萨斯大学休斯顿医学院的卒中中心早期形式数据集的合并造成的，这也是所有结局研究的共同难题。在二次分析中，我们发现丢失的数据集都一致地平均分布于主要的自变量和因变量之间。急性缺血性卒中 rt-PA 静脉溶栓与死亡率增加相关 (12% 对 5.4% [无 rt-PA 组] ; P＜0.0001 ; 表 1)；出院后回家接受临终关怀的似然值无显著统计学差异 (2.5% 对 4% [无 rt-PA 组] ; P=0.1638 ; 表 1)。共有 2756 例患者被纳入独立危险因素分层分析 (表 2 和 3)。在评估人口统计学信息时由于缺少种族变量信息而减少 0.65%。

出院后回家与到其他照料单位（IR、SNF 或 Sub）比较剩下的 2225 例患者，1019 例出院后回家，1206 例患者则转入 IR、SNF 或 Sub。在多变量回归分析中发现所有效应后，发现接受 rtPA 溶栓的急性缺血性卒中患者出院后更有可能直接回家 (P＜0.0001 ; OR, 1.945; 95% CI, 1.538-2.459; 表 4)。增龄 (P＜0.0001 ; OR, 0.967; 95% CI, 0.960-0.974) 和就诊时 NIHSS 评分 (P=0.0001; OR, 0.822; 95% CI, 0.805-0.840) 均与出院后转入其他照料单位相关。

对于急性缺血性卒中患者，静脉内 rt-PA 与出院后去向有关的 OR 值比脑血管病的危险因素高，如心血管疾病 (P=0.187 ; OR, 1.156; 95% CI, 0.932-1.434)、糖尿病 (P=0.041 ; OR, 0.803; 95% CI, 0.650-0.991)、高血压病 (P=0.177 ; OR, 0.850; 95% CI, 0.671-1.076)、高脂血症 (P=0.016; OR, 0.774; 95% CI, 0.628-0.954) 与卒中史 (P=0.023; OR, 1.311;
出院后转到 IR 与其他照料单位 (SNF 或 Sub) 的比较

在剩下的 1206 例急性缺血性卒中患者中，719 例患者出院后转至 SNF 或 Sub。在多变量回归分析调整所有效应后，接受 rt-PA 治疗或未接受 rt-PA 治疗的患者在出院后的去向上无显著的统计学差异 (P=0.123；OR，1.255；95% CI，0.940-1.675；表 5)。

高龄提示出院后易转至 SNF 和 Sub (P<0.0001；OR，0.948；95% CI，0.938-0.958)。与首次分析结果不同，合并心血管疾病预示出院后至 SNF 和 Sub，这确证活动耐力在决定卒中出院后安置中的重要性 (P=0.031；OR，0.741；95% CI，0.564-0.973)。

不受 rt-PA 应用的影响，就诊时 NIHSS 评分高预测出院后至 SNF 和 Sub 的可能性高 (P<0.0001；OR，0.913；95% CI，0.896-0.930)。卒中史也与出院后转至 SNF 和 Sub 相关，这些患者更容易在基线时有躯体功能损害 (P<0.0001；OR，2.424；95% CI，1.784-3.293)。糖尿病、高血压或高脂血症对出院后去向的分布无显著影响 (表 5)。

## 讨论

据我们所知，这是首个有关急性缺血性卒中患者静脉 rt-PA 溶栓治疗与出院后回家或转入其他照料单位所反映的短期预后直接联系的研究。短期结局与长期残疾之间的联系尚未被研究，将是未来研究的焦点。与未行 rt-PA 溶栓治疗的患者相比，接受 rt-PA 溶栓治疗的患者倾向有就诊时的 NIHSS 评分高、年龄轻、胆固醇水平正常、无卒中病史。

在进行本研究期间，前述有关 60% 的规则有变异，对接受 IRFs 的患者有潜在的混杂效应。尽管 2007 年国会通过了医疗保险、医疗补助及 SCHIP 扩大法案，也只有用于 IRF 的花费报销，它对这段时期的出院后去向安排对本分析无影响。今后的研究将受到新的 2010 年医疗保险和医疗补助服务中心的 IRF 覆盖要求的影响。医疗保险和医疗补助服务中心 2010 年指南目的是致力于确定 IRF 的个人申请是否合理和必需。新的覆盖要求提供患者病情确实稳定且可从 IRF 获益，特别是对协调的多学科康复治疗的需要，并指出某个 IRF 所能提供的治疗获益 [13]。这些新指南对转入 IRF 的影响还有待观察，也将是未来研究的课题。

与先前的研究相一致，我们发现就诊时 NIHSS 评分低与出院后直接回家显著相关。然而，rt-PA 的应用与患者出院时良好状况的相关性较强于脑血管病的危险因素，这对应用 rt-PA 作为该人群预后的指标有显著影响。本分析是基于收集的传统 3 小时静脉溶栓时间窗内的数据，今后的研究将会延长至 4.5 小时内。

## 结论

根据我们所知，这是首个有关急性缺血性卒中患者静脉 rt-PA 溶栓治疗与出院后居家或转入其他照料单位所反映的短期预后直接联系的研究。短期结局与长期残疾之间的联系尚未被研究，将是未来研究的焦点。与未行 rt-PA 溶栓治疗的患者相比，接受 rt-PA 溶栓治疗的患者倾向有就诊时的 NIHSS 评分高、年龄轻、胆固醇水平正常、无卒中病史。
化卒中照料可改善结局，但因没有保险或者保险不足，许多患者不能获得急性期后的康复服务。急性期后的康复服务的利用和获得受到年龄、种族和地域不同的影响[14]。高龄既可以作为结果的预测指标，也可作为筛选可能未投保人群符合医疗保险资格的工具[8]。急性期后照料设施主要服务那些无论是通过医保还是自费都有自己经济支付能力的患者。本研究是在具备IRF三级医疗中心开展，因而所有符合标准的患者都被纳入。本研究的结果可能不适用于那些将患者经济条件作为筛查资格的中心。

急性出院后的安置是转入不同照料单位的因素之一。如果一个患者符合IRF的条件，但该患者需要安全监测、有认知障碍或有躯体活动限制，建议在转运完成前对照料者进行确定。这些患者可能转至SNF，通常会呆较长时间，直到确定照料者。估计25%-74%的卒中幸存者的日常活动需要非正式照料者帮助，这些照料者通常是家庭成员[13]。尽管照料行为带来的身体、心理、情感和社会效应及其对社会的经济效益有目共睹，照料者在卒中管理中仍然很少被考虑到，许多照料者感到训练不足、消息闭塞及对出院后提供的支持级别不满意[14]。患者出院后能否直接回家的一个关键决定条件是照料者的能力和身体素质，这与患者的状态无关。这些患者可能适合出院后直接回家，但如果他们的照料者不能满足他们的服务需求则进行IRF或者转至SNF。

我们无法评论那些从IRF再转至其他照料单位的缺血性卒中患者。有一部分患者是不能耐受每天3小时的治疗故而被转至SNF。今后，我们将追踪急性卒中患者在IRF后的安置以获得相关情况。

这是一个回顾性的分析。我们尽量对年龄、卒中严重程度和已知提示预后不良的危险因素进行分层。另外，采用回顾性资料使得难以收集缺失变量，这占25%-74%的卒中幸存者的日常活动需要非正式照料者的帮助，这些照料者通常是家庭成员[13]。尽管照料行为带来的身体、心理、情感和社会效应及其对社会的经济效益有目共睹，照料者在卒中管理中仍然很少被考虑到，许多照料者感到训练不足、消息闭塞及对出院后提供的支持级别不满意[14]。患者出院后能否直接回家的一个关键决定条件是照料者的能力和身体素质，这与患者的状态无关。这些患者可能适合出院后直接回家，但如果他们的照料者不能满足他们的服务需求则进行IRF或者转至SNF。

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总之，在规定的3小时时间窗内接受静脉rt-PA治疗的急性缺血性卒中患者出院后更有可能直接回家而不需要急性期后的住院治疗。急性期中的康复和改进的治疗成本使得净卫生费用减少[3]。传统的康复是促进卒中后恢复进程的一个治疗手段。在卒中急性期后，照料者提高、继续改进患者和照料者的需求、改进健康保健环境等方面还有相当大的空间。

尽管传统的康复治疗药物对患者有帮助，但对卒中治疗的急性缺血性卒中患者出院后更有可能直接回家而不需要急性期后的住院治疗。急性期中的康复和改进的治疗成本使得净卫生费用减少[3]。传统的康复是促进卒中后恢复进程的一个治疗手段。在卒中急性期后，照料者提高、继续改进患者和照料者的需求、改进健康保健环境等方面还有相当大的空间。