Proportion of Patients Treated With Thrombolysis in a Centralized Versus a Decentralized Acute Stroke Care Setting

Maarten M.H. Lahr, MS; Gert-Jan Luijcx, MD, PhD; Patrick C.A.J. Vroomen, MD, PhD; Durk-Jouke van der Zee, PhD; Erik Buskens, MD, PhD

Background and Purpose—Today, treatment of acute stroke consists of tissue-type plasminogen activator (tPA), admission to a stroke unit, and aspirin. Although tPA treatment is the most effective, there is substantial undertreatment. Centralized care may affect rate, timing, and outcome of thrombolysis compared to decentralized treatment in community hospitals. The present study aimed to assess the impact of organizational models on the proportion of patients undergoing tPA treatment.

Methods—A prospective, multicenter, observational study among 13 hospitals in the North of the Netherlands was conducted. In the centralized model, tPA treatment for 4 hospitals was administered in 1 stroke center. The decentralized model comprised 9 community hospitals. Primary outcome was the proportion of patients treated with tPA. Secondary outcome measures were proportion of patients arriving within 4.5 hours, safety, 90-day functional outcome, and onset-to-door, door-to-needle, and onset-to-needle times. Potential confounders were adjusted using logistic regression analysis.

Results—Two hundred eighty-three and 801 ischemic stroke patients were enrolled in the centralized and decentralized settings. Numbers of patients treated with tPA were 62 (21.9%) and 113 (14.1%) (OR, 1.72; 95% CI, 1.22–2.43). Adjusting for potential confounders did not alter results (OR, 2.03; 95% CI, 1.39–2.96). In the centralized setting, significantly more patients arrived at the hospital within the 4.5-hour time window (P<0.01), and shorter door-to-needle times were reached (35 versus 47 minutes). Other secondary outcome measures did not differ across setting.

Conclusions—In a centralized setting, the results demonstrate a 50% increased likelihood of treatment. Prehospital factors seem to contribute to this result. (Stroke. 2012;43:1336-1340.)

Key Words: acute stroke implementation organizational model thrombolysis

Centralized care in stroke centers has been associated with rapid referral and early access to tPA treatment, better functional outcome, and high quality of care. However, reports on a head-to-head comparison between centralized and decentralized care for proportion of patients treated with tPA and outcome are lacking. The aim of this study was to establish a direct comparison of the proportion of patients treated with tPA in centralized organizational setting versus decentralized organizational setting of acute stroke care.

Materials and Methods

Study Design and Patients
This study was a 6-month prospective, multicenter, observational study enrolling all patients admitted with a stroke to hospitals in the 3 Northern provinces of the Netherlands (Figure 1). The Northern region of The Netherlands is an 8.981-km² predominantly urban area with a population of 1.7 million and a population density of 209 inhabitants per square kilometer. Part of the region, covering the catchment area of 4 hospitals, is served according to a centralized model for acute stroke care. The decentralized model serves a population of 577,081 inhabitants with a population density of 247 inhabitants per square kilometer. The function of central stroke center is executed by the Groningen Univer-
Within this catchment area, arrangements are made with emergency medical services and general practitioners to transport patients directly to the central stroke center for examination and possible treatment with tPA. The stroke center has 24-hour, 7-day immediate access to neurological consultation and neuroimaging at the emergency department, stroke physicians available for telephone consultation for all referring general hospitals, and interventional neuroradiology. The remainder of the region is served by 9 general or community hospitals, each attending to acute stroke patients within its catchment area. This region serves a population of 1 137 188 inhabitants with a population density of 181 inhabitants per square kilometer. At the community hospitals, general neurologists and neuroimaging were available 24 hours per day, 7 days per week. Both regions consist of urbanized areas with short distances to surrounding hospitals and similar access to health care services such as the general practitioners office inside and outside business hours, emergency medical services, and hospital services. Emergency medical services protocols for suspected stroke victims were similar for both regions. High prioritization by emergency medical services was defined as ambulance arrival within 15 minutes from the 911 call until ambulance arrival at the location of the patient.

Patients eligible for treatment were treated within a 4.5-hour time window after onset of stroke symptoms according to the ECASS-3 protocol, with the exception that age older than 80 years was allowed, based on our experience in our stroke center and others. Experimental forms of thrombolysis such as local intra-arterial thrombolysis and thrombectomy were not part of the assessment. Data on all patients admitted or referred to hospital and suspected of stroke were collected from February through July 2010. Demographics (age and sex), symp-

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**Figure 1.** Organizational models in the three Northern provinces of The Netherlands.

**Figure 2.** Flow chart of the study. TIA indicates transient ischemic attack; tPA, tissue-type plasminogen activator; INR, international normalized ratio; rTPA, recombinant tissue-type plasminogen activator.
tom onset, arrival time at the hospital, diagnosis, onset time, and treatment with tPA inside and outside business hours and during the weekends were recorded. Initial stroke severity was assessed using the short version of the National Institutes of Health Stroke Scale.\textsuperscript{15}

**Outcome Measures**
The primary outcome measure was the proportion of ischemic stroke patients treated with thrombolysis. Secondary outcome measures were: (1) proportions of patients arriving in time for tPA treatment; (2) the proportion of these patients actually treated with tPA; (3) safety, characterized by the occurrence of symptomatic intracerebral hemorrhage (defined according to the SITS-MOST as a 4-point increase on the National Institutes of Health Stroke Scale score within 36 hours after stroke onset\textsuperscript{16}); (4) functional outcome at 90 days (favorable defined as modified Rankin Score 0–2); (5) onset-to-door, door-to-needle, and onset-to-needle times; and (6) proportion treated outside business hours.

**Statistical Analysis**
We compared the proportion (inclusive of 95% CI) of patients treated with tPA in both organizational models. We considered variables with \( P \leq 0.15 \) on univariate testing for entry into a multivariate logistic regression model. The regression model was used to adjust for possible differences in baseline characteristics potentially confounding the association between determinants and outcome. Odds ratios (OR) and 95\% CI were estimated for determinants of treatment with tPA, functional outcome, and safety. Continuous variables and the different process times were evaluated using ANOVA or the Mann-Whitney \( U \) test. A \( P \leq 0.05 \) was considered significant in the final model. All statistical analyses were performed using SPSS 18 software (Chicago, IL).

**Informed Consent**
Informed consent was obtained from all patients participating in this study.

**Results**

**Patient Characteristics**
A total of 1432 patients were included in the study. Figure 2 shows the distribution of the patients across both settings and the reasons for exclusion from tPA treatment. In the centralized model, more patients were excluded because they had diagnoses other than stroke or because of a transient ischemic attack. In both groups, a comparable proportion of patients were not treated with tPA for various reasons as shown in Figure 2. In Table 1, the baseline characteristics of the overall group of ischemic stroke patients, those arriving at the hospital within 4.5 hours after stroke onset, and, finally, those treated with tPA are shown. In the overall group, patients in the centralized model were more often male and significantly younger. Stroke severity did not differ across settings. For all patients arriving within 4.5 hours and all patients treated with thrombolysis, there were no differences in patient characteristics between both models.

**Primary Outcome**
In the centralized model, 62 of 283 patients (21.9\%) were treated with thrombolysis compared to 113 of 801 (14.1\%) in the decentralized model (OR, 1.72; 95\% CI, 1.22–2.43). After adjustment for stroke severity, age, and gender, the OR for likelihood of treatment with tPA was 2.03 for centralized versus decentralized care (95\% CI, 1.39–2.96).

**Secondary Outcomes and Safety**
Table 2 shows the secondary outcome measures. The proportion of patients arriving in time for tPA treatment was significantly higher in the centralized model (124 of 283 versus 227 of 801; \( P < 0.01 \)). In both models, the proportion of treatment of stroke patients arriving within 4.5 hours after stroke onset was the same (62 of 124 versus 113 of 227; \( P = 0.81 \)). In the centralized model, 41 of 62 (66\%) of the patients displayed a favorable functional outcome compared to 59 of 113 (52\%) in the decentralized model. This was, however, not statistically significant in univariate (OR, 1.79; 95\% CI, 0.94–3.40) or multivariate analysis (OR, 1.62; 95\% CI, 0.76–3.42). Symptomatic intracerebral hemorrhage occurred in 1 of 62 patients (1.6\%) in the centralized model and in 3 of 113 patients (4.1\%) in the decentralized model (OR, 0.60; 95\% CI, 0.06–5.90). Odds for symptomatic intracerebral hemorrhage remained similar after adjustment for stroke severity, age, and gender (OR, 0.82; 95\% CI, 0.08–8.82).

### Table 1. Baseline Characteristics

<table>
<thead>
<tr>
<th>All ischemic stroke patients</th>
<th>Centralized Model</th>
<th>Decentralized Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td>283</td>
<td>801</td>
</tr>
<tr>
<td>Age (y), mean (SD)</td>
<td>70 (14)</td>
<td>73 (13)*</td>
</tr>
<tr>
<td>Male, (%)</td>
<td>158 (56)</td>
<td>391 (49)*</td>
</tr>
<tr>
<td>Short version of NIHSS on arrival (IQR), median</td>
<td>1 (0–3)</td>
<td>1 (0–3)</td>
</tr>
<tr>
<td>Referral GP (%)</td>
<td>135 (48)</td>
<td>456 (57)</td>
</tr>
<tr>
<td>First responder EMS (%)</td>
<td>84 (30)</td>
<td>184 (23)*</td>
</tr>
<tr>
<td>Transported by EMS (%)</td>
<td>213 (75)</td>
<td>460 (57)*</td>
</tr>
<tr>
<td>High prioritization by EMS (%)</td>
<td>170 (80)</td>
<td>311 (68)*</td>
</tr>
<tr>
<td>Median distance to hospital (km)</td>
<td>13.5</td>
<td>8.5†</td>
</tr>
<tr>
<td>Patients arriving within 4.5 hours after stroke onset (n (%))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (y), mean (SD)</td>
<td>69 (14)</td>
<td>71 (13)</td>
</tr>
<tr>
<td>Male, (%)</td>
<td>63 (49)</td>
<td>124 (54)</td>
</tr>
<tr>
<td>Short version of NIHSS on arrival (IQR), median</td>
<td>2 (0–4)</td>
<td>2 (0–5)</td>
</tr>
<tr>
<td>Referral GP (%)</td>
<td>63 (51)</td>
<td>108 (48)</td>
</tr>
<tr>
<td>First responder EMS (%)</td>
<td>53 (43)</td>
<td>110 (48)</td>
</tr>
<tr>
<td>Transported by EMS (%)</td>
<td>115 (93)</td>
<td>181 (80)*</td>
</tr>
<tr>
<td>High prioritization by EMS (%)</td>
<td>109 (95)</td>
<td>162 (90)</td>
</tr>
<tr>
<td>Median distance to hospital (km)</td>
<td>22.1</td>
<td>8.3†</td>
</tr>
<tr>
<td>Patients treated with tPA (n (%))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (y), mean (SD)</td>
<td>69 (16)</td>
<td>70 (14)</td>
</tr>
<tr>
<td>Male, (%)</td>
<td>35 (56)</td>
<td>60 (53)</td>
</tr>
<tr>
<td>Short version of NIHSS on arrival (IQR), median</td>
<td>4 (2–7)</td>
<td>4 (2–7)</td>
</tr>
<tr>
<td>Referral GP (%)</td>
<td>27 (44)</td>
<td>35 (31)</td>
</tr>
<tr>
<td>First responder EMS (%)</td>
<td>31 (50)</td>
<td>71 (63)</td>
</tr>
<tr>
<td>Transported by EMS (%)</td>
<td>59 (95)</td>
<td>98 (87)</td>
</tr>
<tr>
<td>High prioritization by EMS (%)</td>
<td>55 (93)</td>
<td>94 (96)</td>
</tr>
<tr>
<td>Median distance to hospital (km)</td>
<td>23.1</td>
<td>8.8†</td>
</tr>
</tbody>
</table>

*EMS indicates emergency medical services; GP, general practitioner; IQR, interquartile range; NIHSS, National Institutes of Health Stroke Scale; SD, standard deviation; tPA, tissue-type plasminogen activator.

\*\( P < 0.05 \).

†\( P < 0.01 \).
median onset-to-door time for all patients treated with thrombolysis was 1 hour 24 minutes for the centralized setting and 1 hour 12 minutes for the decentralized model (P=0.12). The median door-to-needle time was 35 minutes for the centralized model compared to 47 minutes in the decentralized model (P=0.01). The total median onset-to-needle time was 124 minutes for the centralized setting and 120 minutes for the decentralized setting (P=0.75). In both settings, there was no difference in proportion of patients treated inside or outside business hours. In the centralized model, 25 of 62 (40%) patients were treated with tPA outside business hours compared to 54 of 113 (40%) in the decentralized model.

**Discussion**

This study demonstrates that the proportion of patients treated with tPA is different for 2 contrasting organizational models of acute stroke care. The likelihood of treatment was almost twice as high in the centralized setting compared to decentralized setting. Among patients arriving within 4.5 hours at the hospital, thrombolysis rates were similar for both models. This suggests that the effect on proportions treated with thrombolysis is mainly caused by prehospital factors. The centralized organizational model yielded a larger proportion of patients arriving within 4.5 hours after stroke onset and a significantly shorter door-to-needle time. The latter was subsequently offset by a longer onset-to-door time, ultimately leading to a similar overall process time (onset-to-needle time). As far as functional outcome at 90 days was concerned, patients treated with tPA in the centralized model had more favorable outcomes; however, the difference was not significantly different from the outcome in the decentralized model in the univariate or multivariate analysis. Safety was similar in both organization models.

The overall results of our study indicate that the organization of acute stroke care across the northern part of The Netherlands surpassed national averages. The high proportion of patients treated in the centralized model is in line with results published for other stroke centers. The proportion of patients treated in the decentralized model was higher than reported previously. Importantly, no interventions were executed to increase thrombolysis rates during the period of data collection, because this was an observational study. Interestingly, any beneficial effect of centralizing stroke care might be further augmented when performed in regions with lower treatment rates than the ones achieved in the decentralized model in our study.

Stroke patients presenting to the emergency department within 4.5 hours had similar chances of receiving thrombolysis regardless of setting. However, many more patients presented within 4.5 hours in the centralized model. These results suggest that, in our region, treatment rates may largely depend onprehospital factors. The difference in the proportion of patients arriving within 4.5 hours for both models may have several causes. First, within the centralized model a greater awareness of tPA treatment may exist among caregivers. Within the literature, the more experienced stroke caregivers. Within the literature, the more experienced stroke workforce. Second, a referral preference may exist for the centralized setting. Although not directly measured in this study, an increased awareness can be the result of a combination of experience and exposure to tPA, continuing medical education, and new trainees entering the workforce. Second, a referral preference may exist for the centralized model. The better intrahospital logistics, as indicated by shorter door-to-needle time and the trend toward better functional outcome, may be among the factors that determine possible preferences. As yet, the extent of and reasons for any such preference are unknown and require further study. Third, within the decentralized model, use of emergency medical services and high prioritization were significantly lower. This may have contributed to delayed arrival patterns and, subsequently, fewer patients arriving within 4.5 hours at the hospital in this group. High prioritization of emergency medical services occurred significantly more frequently in the centralized model, possibly indicating more calls recognized as medical emergency. Patients transported in the decentralized model had significantly shorter median distances to the hospital, explaining the shorter onset-to-door times in this region. Finally, patients were older and more frequently women in the decentralized region, possibly reflecting a higher percentage of people living alone, adding to delayed hospital arrival.

Because treatment with thrombolysis remains underused, attempts have been made to improve implementation. Treatment with thrombolysis is a complex multifaceted intervention. It is challenging to identify critical success factors along the entire care pathway, both in the prehospital and in-hospital phases. Typically, classic experimental study designs are performed. For example, a 2-year implementation study for thrombolysis was recently evaluated. This study resulted in a negligible increase of thrombolysis rate from 12% in the control group to 13% in the interventional group. The question arises whether such research methods are an efficient way to study and improve implementation of com-

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**Table 2. Secondary Outcomes Measures in Relation to Organizational Model Acute Stroke Care**

<table>
<thead>
<tr>
<th>All Patients</th>
<th>Centralized Model, n (%)</th>
<th>Decentralized Model, n (%)</th>
<th>OR (95% CI), Unadjusted</th>
<th>OR (95% CI), Adjusted for Patient Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>283</td>
<td>801</td>
<td></td>
<td></td>
</tr>
<tr>
<td>siCH</td>
<td>1/62 (2)</td>
<td>3/113 (3)</td>
<td>0.60 (0.06–5.90)</td>
<td>0.82 (0.08–8.82)</td>
</tr>
<tr>
<td>mRS ≤2 at 90 d</td>
<td>41/62 (66)</td>
<td>59/113 (52)</td>
<td>1.79 (0.94–3.40)</td>
<td>1.62 (0.76–3.42)</td>
</tr>
<tr>
<td>Patient arriving in time for treatment with tPA</td>
<td>124/283 (44)</td>
<td>227/801 (28)*</td>
<td>1.94 (1.46–2.56)</td>
<td>1.99 (1.49–2.66)</td>
</tr>
<tr>
<td>Patients arriving in time and treated with tPA</td>
<td>62/124 (50)</td>
<td>113/227 (50)</td>
<td>1.16 (0.76–1.77)</td>
<td>1.30 (0.79–2.14)</td>
</tr>
<tr>
<td>Patients treated with tPA outside business hours</td>
<td>25/62 (40)</td>
<td>45/113 (40)</td>
<td>1.01 (0.55–1.87)</td>
<td>1.02 (0.55–1.90)</td>
</tr>
</tbody>
</table>

CI indicates confidence interval; OR, odds ratio; mRS, modified Rankin Scale; siCH, symptomatic intracerebral hemorrhage; tPA, tissue-type plasminogen activator.

*P<0.01.
plex treatment trajectories. Other research methodologies may be required such as discrete event simulation.28,29

There are some limitations to this study. Sociodemographic factors such as living status and recognition of stroke symptoms by bystanders were not collected in this study and could not be corrected for in the multivariate regression analyses. Initial stroke severity on hospital arrival may have been slightly underestimated in both organizational models because of use of the shortened version of the National Institutes of Health Stroke Scale.

In conclusion, this study revealed that the proportion of patients treated with tPA in a centralized setting of acute stroke care surpassed that achieved in a decentralized setting considerably. Prehospital factors seem particularly relevant targets for improvement.

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Disclosures

None.

References


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