ACHC®

Review of 2025 Performance
in ACHC-certified Stroke Centers

BENCHMARKING QUALITY

ACHC's aim is to deliver the best possible accreditation experience as a valued partner for healthcare organizations committed to improving their quality of care. We accomplish this goal through relevant standards and continuing education, with a focus on patient safety and business sustainability.

INTRODUCTION

ACHC Stroke Certification Standards require programs to collect and report data on performance measures. The data must be available for review at the time of survey as demonstration of ongoing quality improvement efforts. Sharing the data in this comparative review:

- Augments the culture of community and collaborative learning established by ACHC's quarterly practice-sharing teleconferences for stroke programs.
- Supports individual stroke centers by providing a resource that allows them to assess their performance against that of peer programs. "Peer-ness" is established in two ways. First, data are grouped in cohorts of related patient volume as indicated in the chart below. Secondly, individual organizations are color coded on the graphs to identify their certification level.
- Evaluates the effectiveness of ACHC Certification as a driver of quality care for stroke patients.

Interpreting the Report

Each hospital is assigned an ID number that has been communicated to the stroke program coordinator. For each performance measure, the individual results of participating hospitals are graphed using these IDs. Data are grouped in cohorts of related patient volume and color-coded based on certification program: **Stroke Ready**, Primary Stroke, and Thrombectomy/Comprehensive Stroke.

PATIENT COUNT	ORG ID
1–99	**101 – 133**
100–299	**201 – 270**
300–599	**300 – 353**
600+	**400 – 433**

Below each graph is a description of what is being measured along with comments that describe best practice and summarize the overall analysis.

The results demonstrate that **ACHC-certified stroke centers continue to meet or exceed the benchmarks established as national goals**.

Using the data

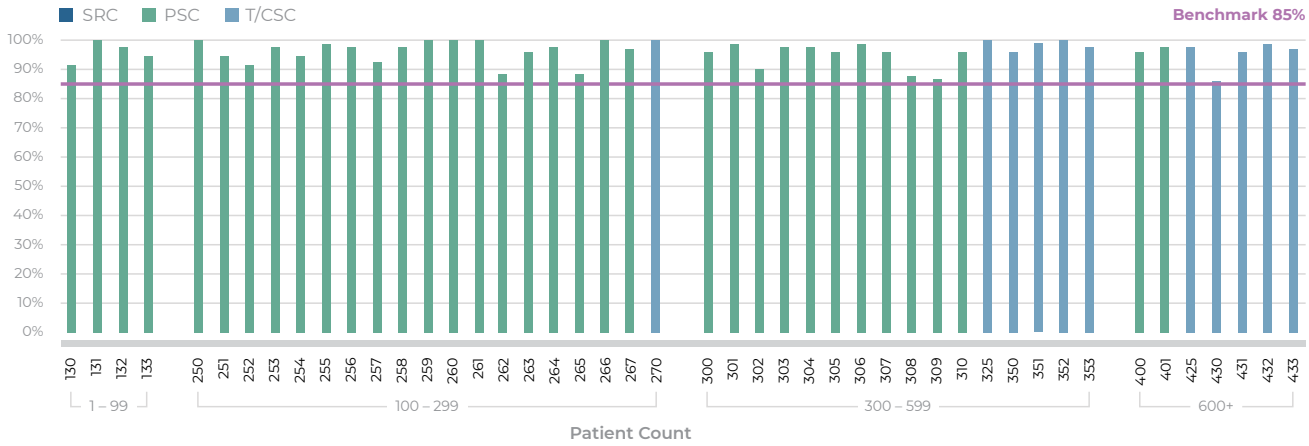
Communication is essential for sustaining improvements. Use the steps below to deepen the value of your analysis of the data in this report for your organization.

	ANALYZE	COMMUNICATE
1	Identify your organization. Or find the group that represents the certification option appropriate to your program.	Share this report (and your analysis) with your stroke staff to show how their patient care is reflected in the data.
2	Compare your performance to that of your peer organizations and the overall group.	Share this report with your Board, medical staff, leadership team, and hospital staff as evidence of the quality care you provide.
3	Compare your results with your community needs assessment. *Does your stroke program meet the goals set in that report?*	Share this report with your marketing department to encourage active support of your program. Share relevant results at your community education events.

As always, the ACHC team is here to support each program with opportunities for education, for connection, and for consultation.

We welcome feedback and hope that you will find this report useful to your Stroke Program.

SM-1: *Venous Thromboembolism (VTE) Prophylaxis*



Success rate: 100% of ACHC-certified programs met or exceeded the benchmark.*

Comparison to past performance: improvement from 96% in 2023.

*This measure is not required for Stroke Ready Centers.

What is being measured?

The percentage of patients diagnosed with acute ischemic stroke and assessed to be at risk for VTE who received relevant intervention.

Relevant standard: 02.02.03 for Primary Stroke Centers, Thrombectomy Stroke Centers, and Comprehensive Stroke Centers.

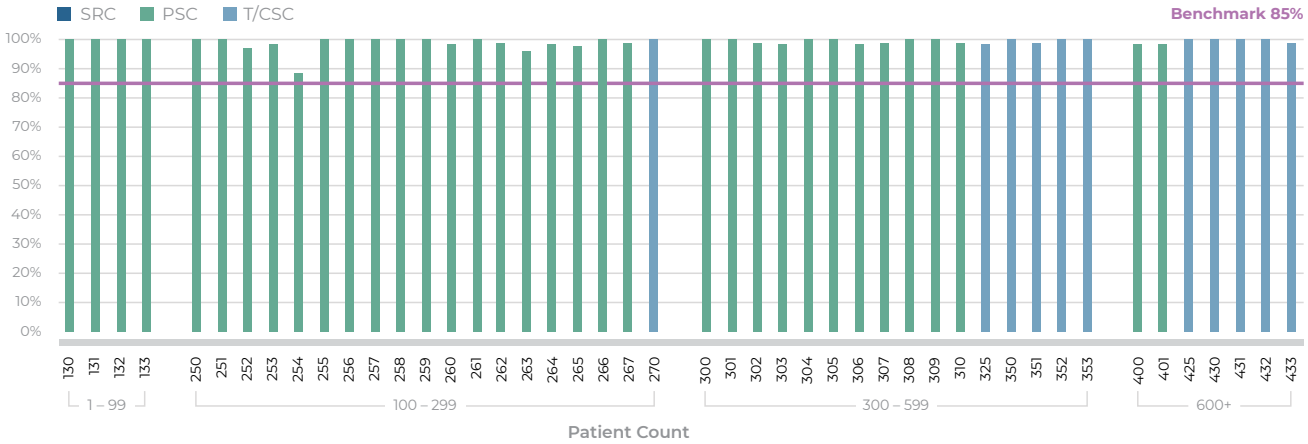
Best practice

Complete a VTE risk assessment at the time of admission. The application of sequential compression devices, anticoagulation medication, and early mobilization are the accepted interventions to address this risk.

Comment

All organizations met the benchmark of 85%. Only seven organizations reported a VTE prophylaxis rate under 95% indicating that improvement beyond the benchmark should be an achievable stretch goal for all ACHC-certified stroke centers.

SM-2: *Discharged on Antithrombotic Therapy*



Success rate: 100% of ACHC-certified programs met or exceeded the benchmark.*

Comparison to past performance: improvement from 94% in 2023.

*This measure is not required for Stroke Ready Centers.

What is being measured?

The percentage of ischemic stroke patients who were prescribed antithrombotic therapy (anti-platelet and anticoagulants) at hospital discharge.

Relevant standard: 02.02.03 for Primary Stroke Centers, Thrombectomy Stroke Centers, and Comprehensive Stroke Centers.

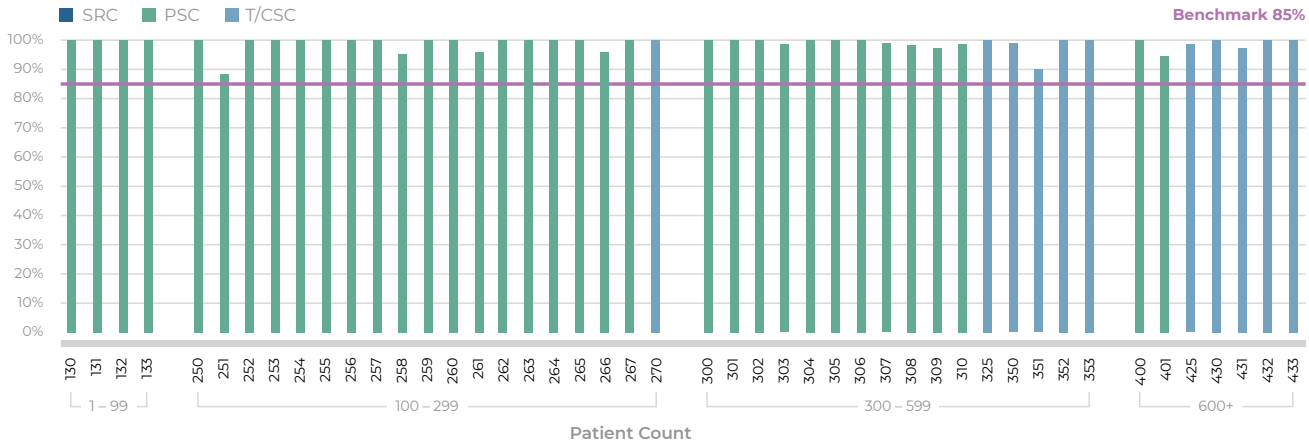
Best practice

All ischemic stroke patients should be discharged with a prescription for an antithrombotic. If antithrombotic therapy is not prescribed, the reason should be documented in the medical record. Having the stroke coordinator or a program champion review patient records in real time can ensure that expected medications have been ordered.

Comment

All organizations met the benchmark of 85%. Only one organization reported a percentage under 95%. Year-over-year, ACHC-certified hospitals have routinely exceeded the benchmark for this metric which is tied to the standard of care.

SM-3: *Anticoagulation Therapy for AF/Flutter*



Success rate: 100% of ACHC-certified programs met or exceeded the benchmark.*

Comparison to past performance: improvement from 98% in 2023.

*This measure is not required for Stroke Ready Centers.

What is being measured?

The percentage of ischemic stroke patients with a clinical diagnosis of atrial fibrillation/flutter who are prescribed anticoagulation therapy at the time of discharge.

Relevant standard: 02.02.03 for Primary Stroke Centers, Thrombectomy Stroke Centers, and Comprehensive Stroke Centers.

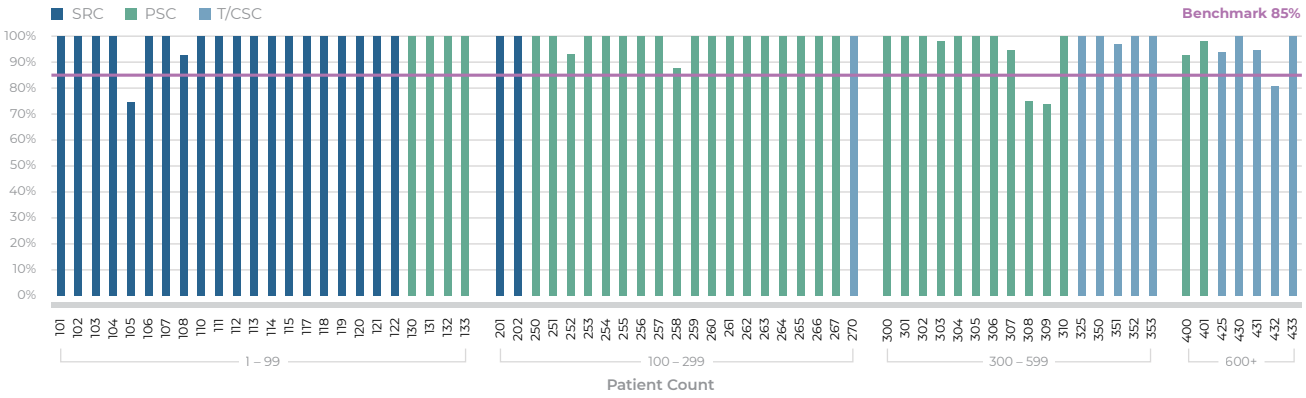
Best practice

Cardiac monitoring for 24 hours after admission may be helpful in diagnosing AF/flutter. If anticoagulation therapy is not prescribed at discharge, there must be documentation in the medical record of the reason for this clinical decision.

Comment

All organizations met the benchmark of 85%. Only one organization reported a percentage under 90%. Year-over-year, ACHC-certified hospitals have routinely performed well on this metric tied to the standard of care.

SM-4: *Thrombolytic Therapy within 4.5 hours*



Success rate: 94% of ACHC-certified programs met or exceeded the benchmark.

Comparison to past performance: improvement from 93% in 2023.

What is being measured?

The percentage of acute ischemic stroke patients who arrive at the hospital within 3.5 hours (210 minutes) of time last known well and for whom IV tPA was initiated at this hospital within 4.5 hours (270 minutes) of time last known well.

Relevant standard: 02.00.06 for Stroke Ready Centers, Primary Stroke Centers, Thrombectomy Stroke Centers, and Comprehensive Stroke Centers.

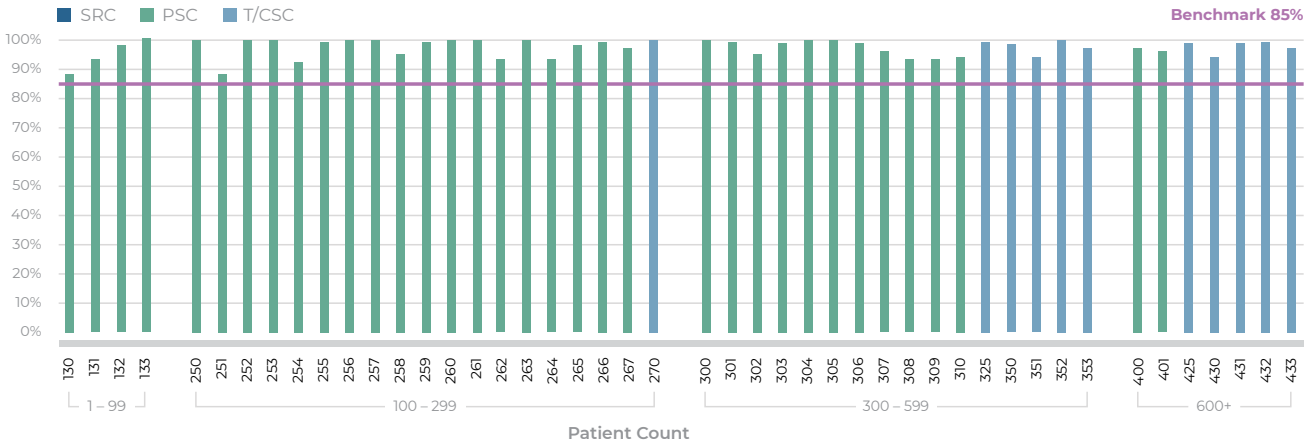
Best practice

When the 4.5-hour benchmark is missed, a documented explanation by the practitioner responsible for care of the patient appears in the medical record. For example, a delay due to clinical care like blood pressure or airway management would be reflected in the record.

Comment

Five hospitals fell below the benchmark but among the others, 84% representing all certification types and across all patient count cohorts exceeded the benchmark for every eligible patient at 100%. This indicates a viable improvement opportunity for the other programs.

SM-5: *Antithrombotic Therapy (End of Day 2)*



Success rate: 100% of ACHC-certified programs met or exceeded the benchmark.*

Comparison to past performance: improvement from 98% in 2023.

*This measure is not required for Stroke Ready Centers.

What is being measured?

The percentage of ischemic stroke patients administered antithrombotic therapy by the end of hospital day two. Antithrombotic therapy includes anti-platelet and anticoagulant medications.

Relevant Standard: 02.02.03 for Primary Stroke Centers, Thrombectomy Stroke Centers, and Comprehensive Stroke Centers.

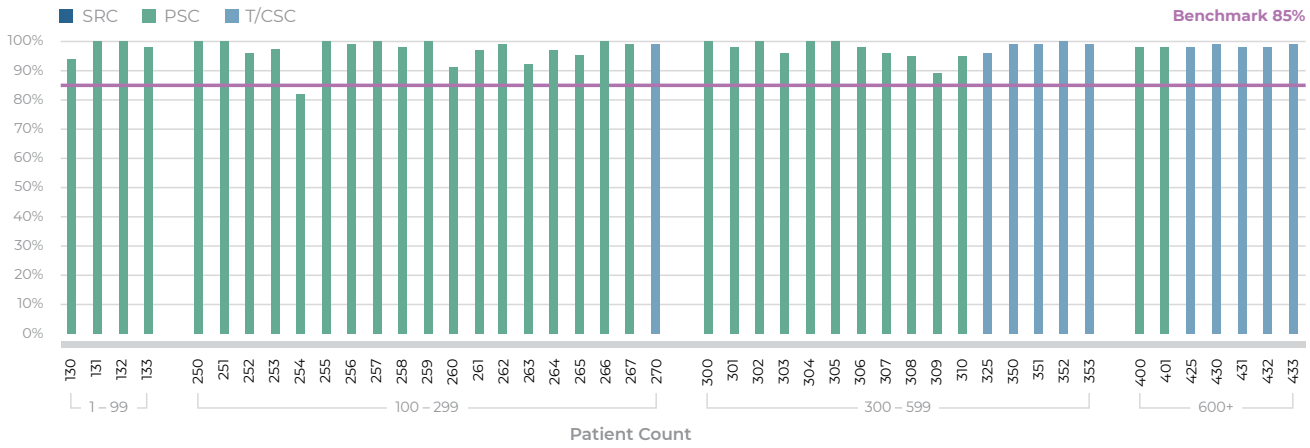
Best practice

Real time review of patient records can help the medical team catch instances when expected medications have not been ordered.

Comment

While all organizations met the benchmark, more than half (54%) achieved 99 – 100% success in providing antithrombotic therapy to all eligible patients by the end of hospital day two.

SM-6: *Discharged on Statin Medication*



Success rate: 98% of ACHC-certified programs met or exceeded the benchmark.*

Comparison to past performance: = 98% in 2023.

*This measure is not required for Stroke Ready Centers.

What is being measured?

The percentage of ischemic stroke or TIA patients with clinical ASCVD who were prescribed a statin medication at discharge.

Relevant Standard: 02.02.03 for Primary Stroke Centers, Thrombectomy Stroke Centers, and Comprehensive Stroke Centers.

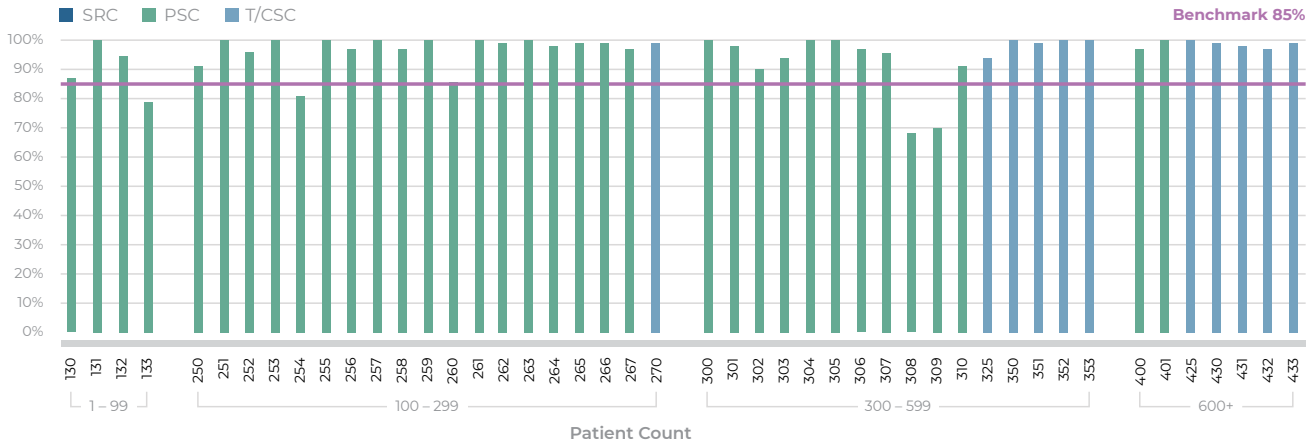
Best practice

The expectation is discharge on a high intensity statin when appropriate or documentation demonstrating why a statin could not be ordered, e.g., allergy or intolerance by patient. Most programs find it helpful to have real-time medical record review to catch instances when expected medications have not been ordered.

Comment

One Primary Stroke Center missed the benchmark at 82% and one additional program recorded 89% of eligible patients were prescribed a statin at discharge. All other organizations were above 90%.

SM-8: *Stroke Education*



Success rate: 92% of ACHC-certified programs met or exceeded the benchmark.

Comparison to past performance: improvement from 83% in 2023.

*This measure is not required for Stroke Ready Centers.

What is being measured?

The percentage of stroke patients or their caregivers who were provided educational materials during the hospital stay. Education topics included activation of emergencymedical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.

Related Standard: 02.02.06 for Primary Stroke Centers, Thrombectomy Stroke Centers, and Comprehensive Stroke Centers.

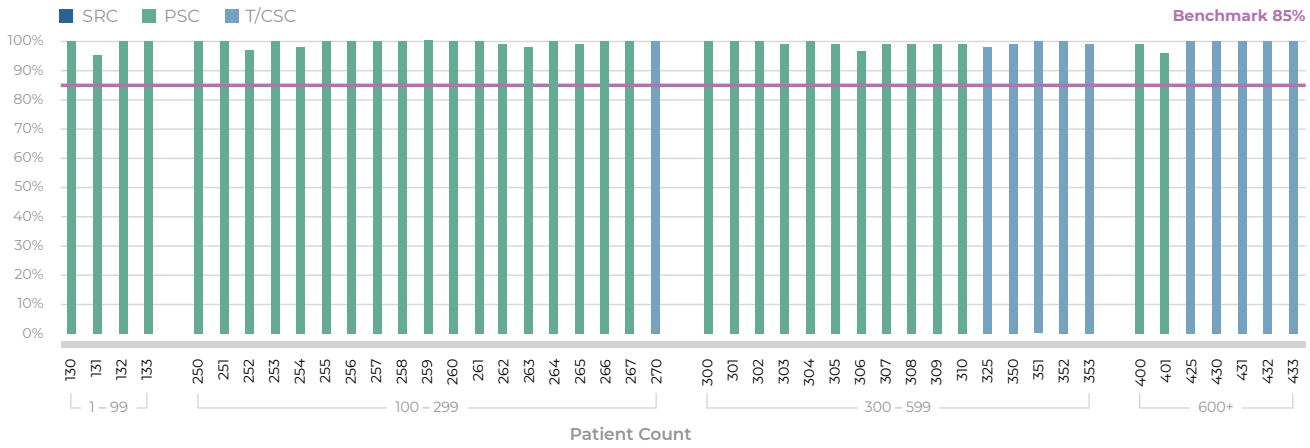
Best practice

In keeping with ACHC's intent to be a resource partner to the organizations we serve, we emphasize the value of an educational approach to health care. Our expectation is that stroke centers take a similar approach and are prepared with materials for patients and their caregivers to help them understand and effectively advocate for their care.

Comment

This year's significant improvement in performance is encouraging but still below the historic high of 96% in 2020. Often surveyors find that this is a documentation issue with staff neglecting to note the education provided in the patient's record. It may also be seen as less critical than other clinical aspects of care, but well-informed patients are more likely to adhere to medication and rehabilitation regimens.

SM-10: *Rehabilitation Assessment*



Success rate: 100% of ACHC-certified programs met or exceeded the benchmark.*

Comparison to past performance: = 100% in 2023.

*This measure is not required for Stroke Ready Centers.

What is being measured?

The percentage of ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services. Initial physical rehabilitation must be conducted by a physical therapist and may include occupational therapy or speech and language therapy as identified by clinical needs assessment.

Relevant Standard: 02.02.04 for Primary Stroke Centers, Thrombectomy Stroke Centers, and Comprehensive Stroke Centers.

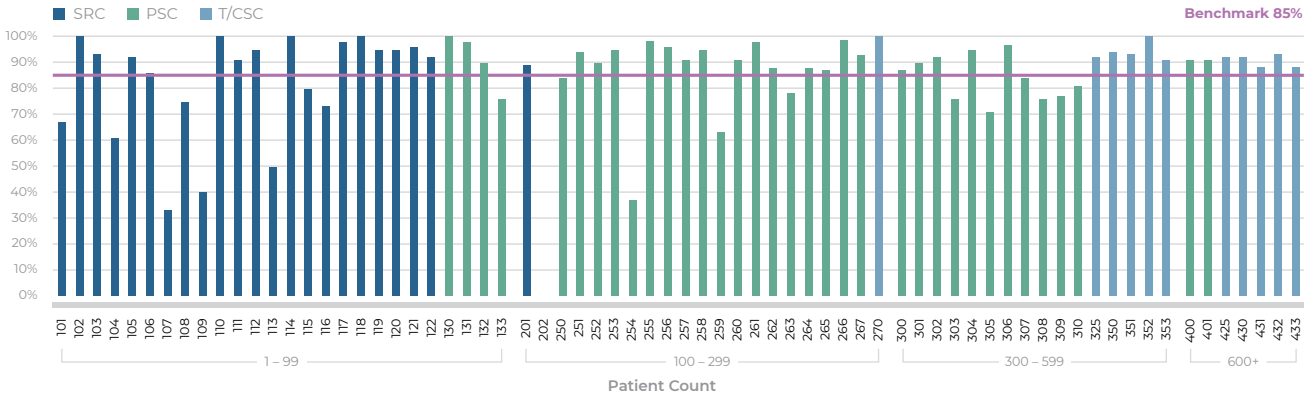
Best practice

Stroke order sets include patient evaluation by a physical therapist to trigger an order for the rehabilitation department.

Comment

All reporting hospitals surpassed the benchmark threshold for provision of assessment of stroke patients for rehabilitation services with an aggregate average performance of 99%.

SM-11: *Dysphagia Screening*



Success rate: 71% of ACHC-certified programs met or exceeded the benchmark.

Comparison to past performance: decline from 80% in 2023.

What is being measured?

The percentage of stroke patients screened for dysphagia prior to receiving anything by mouth.

Relevant Standard: 02.02.02 for Stroke Ready Centers, Primary Stroke Centers, Thrombectomy Stroke Centers, and Comprehensive Stroke Centers.

Best practice

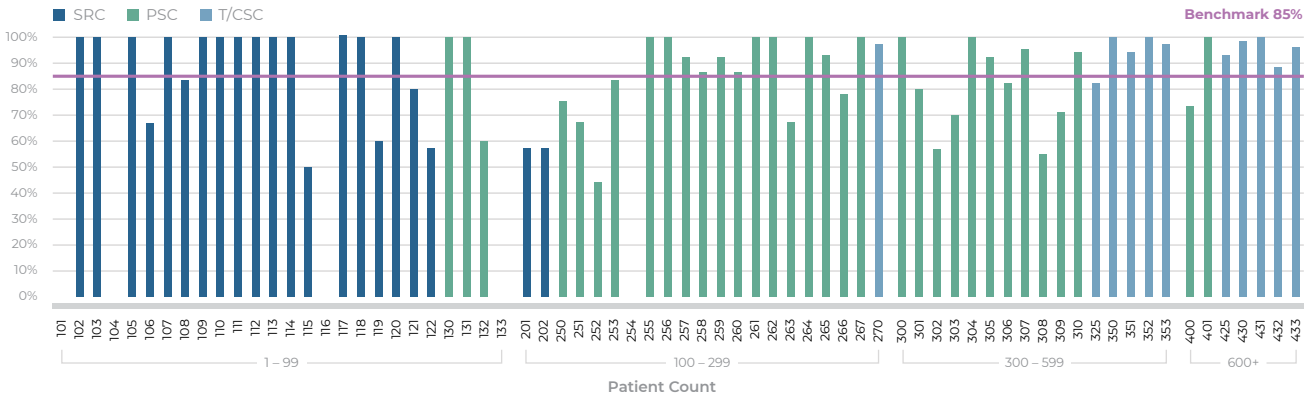
If a patient presents in the emergency department with potential symptoms of stroke, the patient is kept NPO (nothing by mouth) until the dysphagia screen is completed and documented. A patient subsequently transferred from the ED to a hospital with a higher level of care may be counted in the numerator when scoring the measure.

Comment

Hospitals consistently show lower success at achieving this benchmark than the goal set for other performance measures. In 2025, 38% of Stroke Ready Centers and 32% of Primary Stroke Centers fell short of the benchmark. All Thrombectomy and Comprehensive Stroke Centers achieved the benchmark with an aggregate average score of 93%.

SM-12: *Door-to-Needle Time*

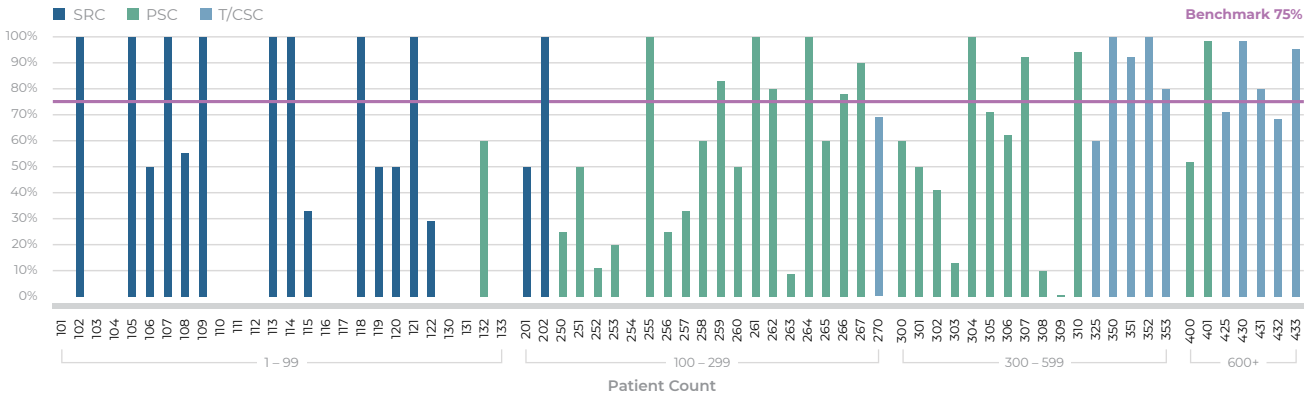
SM-12A: Door-to-Needle Time — 60 Minutes



Success rate: 59% of ACHC-certified programs met or exceeded the benchmark.

Comparison to past performance: improvement from 57% in 2023.

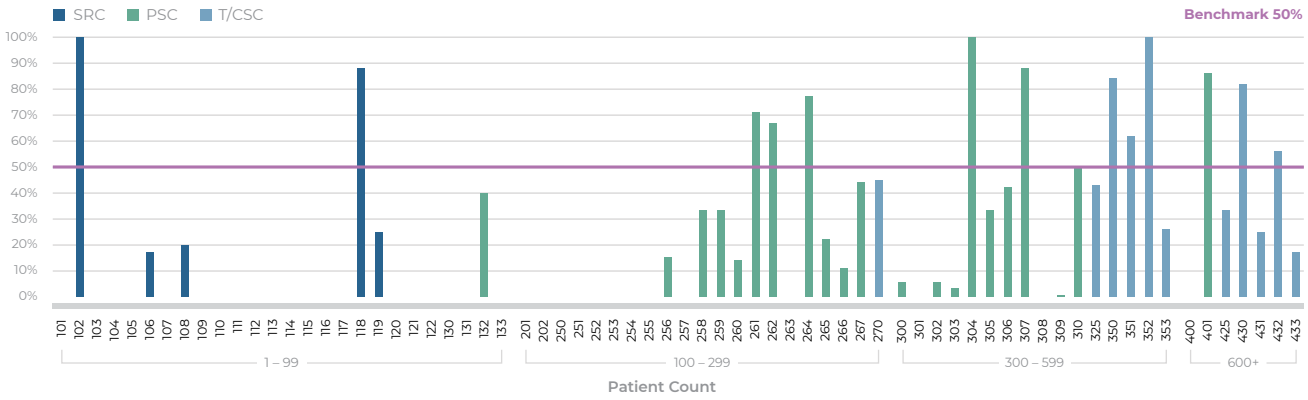
SM-12B: Door-to-Needle Time — 45 Minutes



Success rate: 38% of ACHC-certified programs met or exceeded the benchmark.

Comparison to past performance: improvement from 25% in 2023.

SM-12C: Door-to-Needle Time — 30 Minutes



Success rate: 19% of ACHC-certified programs met or exceeded the benchmark.

Comparison to past performance: decline from 39% in 2023.

What is being measured?

The percentage of acute ischemic stroke patients age 18 years and older who receive intravenous tissue plasminogen activator (tPA) or tenecteplase (TNK) therapy within defined time frames from hospital arrival to administration (door-to-needle).

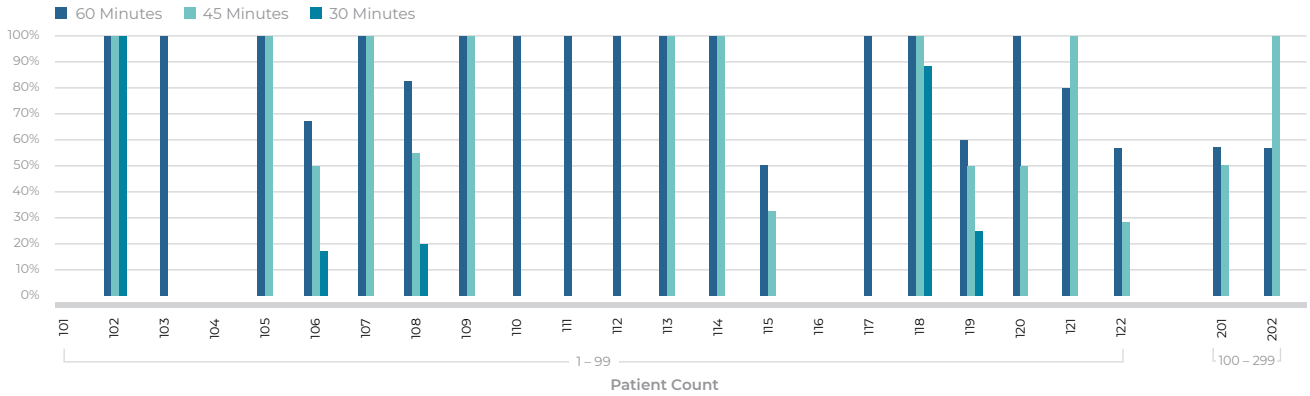
Relevant Standard: 02.00.06 for all certification programs.

Best Practice

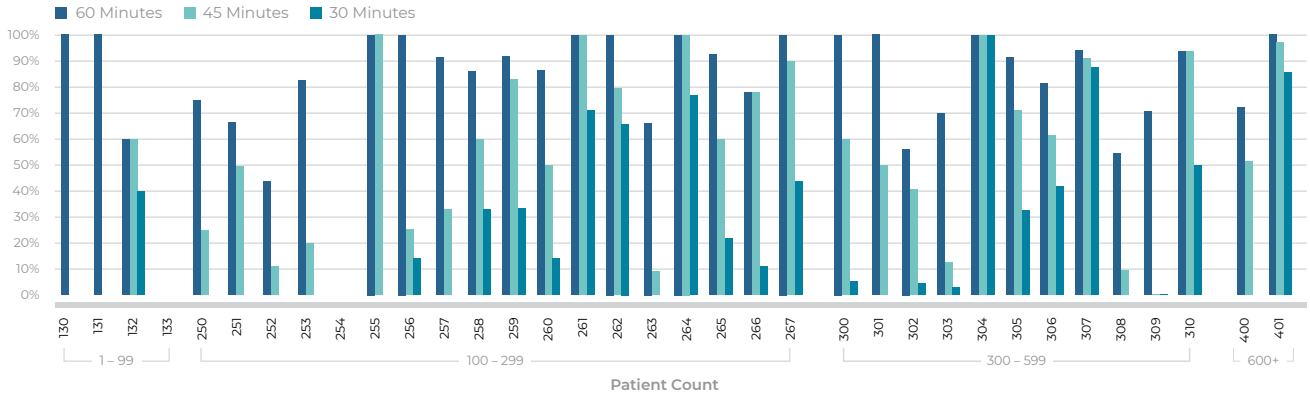
The goal of these metrics is to drive accelerated delivery of tPA/TNK therapy. Meeting patients at the door, performing a quick assessment, and taking the patient directly to CT can help reduce door-to-needle times. Perform a deep dive analysis to identify process breakdowns, e.g., missed identification of subtle symptoms, delays in obtaining IV lines and blood work after CT scan, delayed consultations with a neurologist for an order, etc.

SM-12A, B, C: *Results by Program*

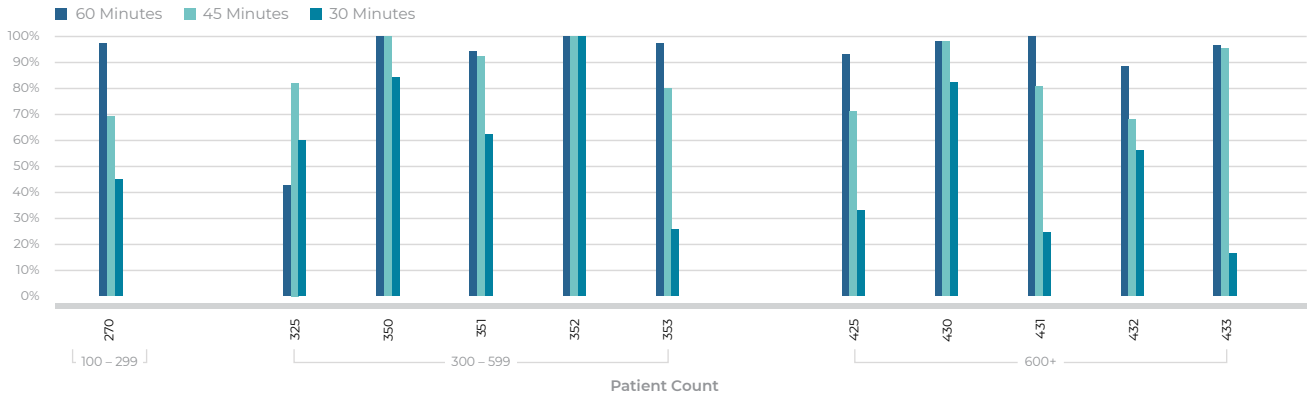
Stroke Ready Centers: Door-to-Needle Times



Primary Stroke Centers: Door-to-Needle Times



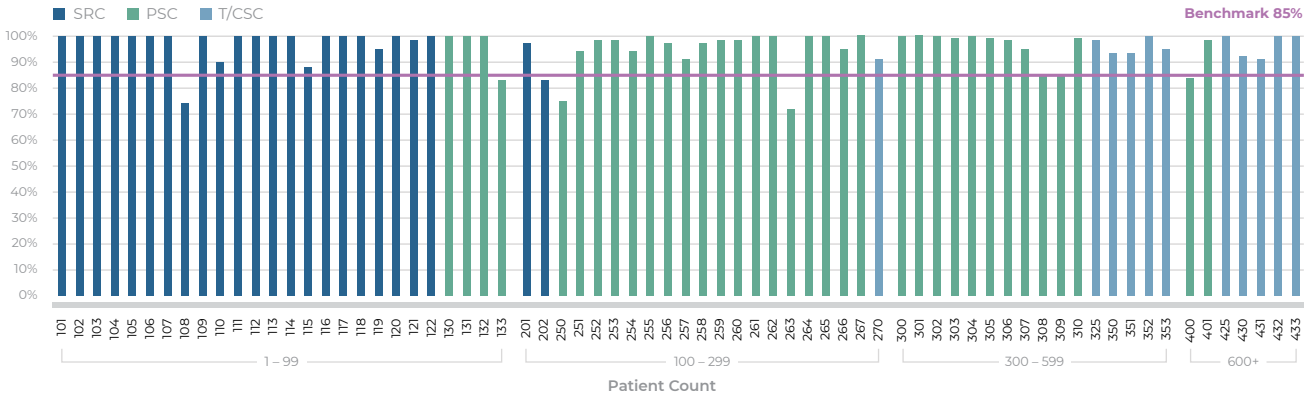
Thrombectomy/Comprehensive Stroke Centers: Door-to-Needle Times



Comment

The three graphs above show the performance by hospital across all three measures. In most cases, data show equal or declining performance as the time frame is reduced. Individual clinical circumstances will dictate the initiation of tPA/TNK which accounts for some of the variance. Not all hospitals reported on all three measures.

SM-13: *Stroke Team Arrival*



Success rate: 93% of ACHC-certified programs met or exceeded the benchmark.

Comparison to past performance: ↑ improvement from 89% in 2023.

What is being measured?

The stroke team's rate of success at arriving within 15 minutes or less (depending on hospital policy) at the bedside of an ED patient presenting with stroke symptoms or following an admitted inpatient's onset of symptoms.

Relevant Standard: 02.03.03 for all programs.

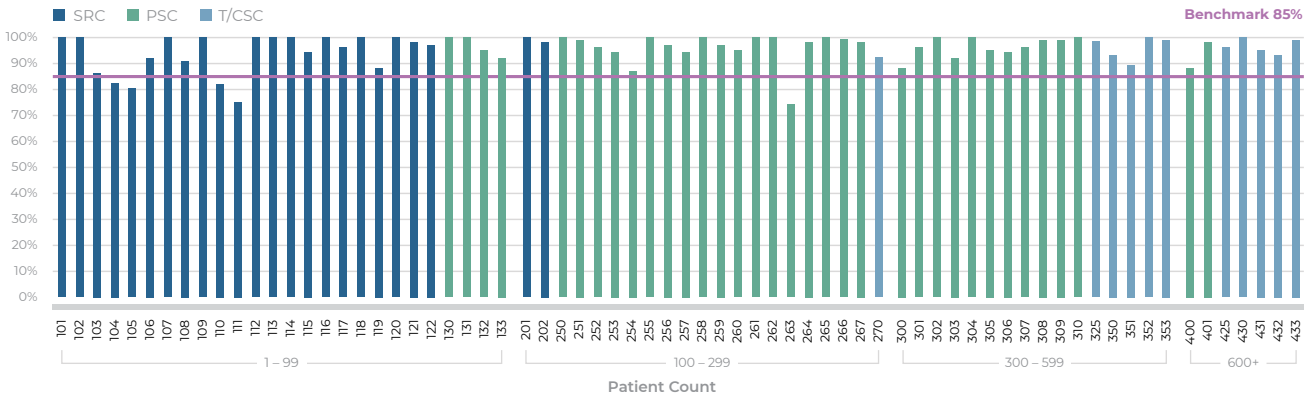
Best practice

Establish a protocol for close communication with the EMS regarding actual arrival time to assist in meeting this measure. For inpatients, educate staff on when to call a rapid response or stroke alert for a change in condition.

Comment

Five organizations missed the benchmark; two Stroke Ready Centers and three Primary Stroke Centers. Of the 89% that achieved the benchmark, 49% reported the stroke team was at the patient's bedside with 15 minutes for every alert called. This is an exceptional result for these organizations.

SM-14: *Glucose Results*



Success rate: 93% of ACHC-certified programs met or exceeded the benchmark.

Comparison to past performance: ↑ improvement from 92% in 2023.

What is being measured?

The percentage of stroke patients with lab testing drawn and results delivered within 45 minutes of arrival in the ED and inpatients with lab testing drawn and results delivered within 45 minutes of onset of symptoms.

Lab testing for this turnaround-time measure includes point-of-care glucose testing; INR and PT and PTT (if indicated); and other tests per stroke protocol/physician order.

Relevant Standard: 02.00.05 for all programs.

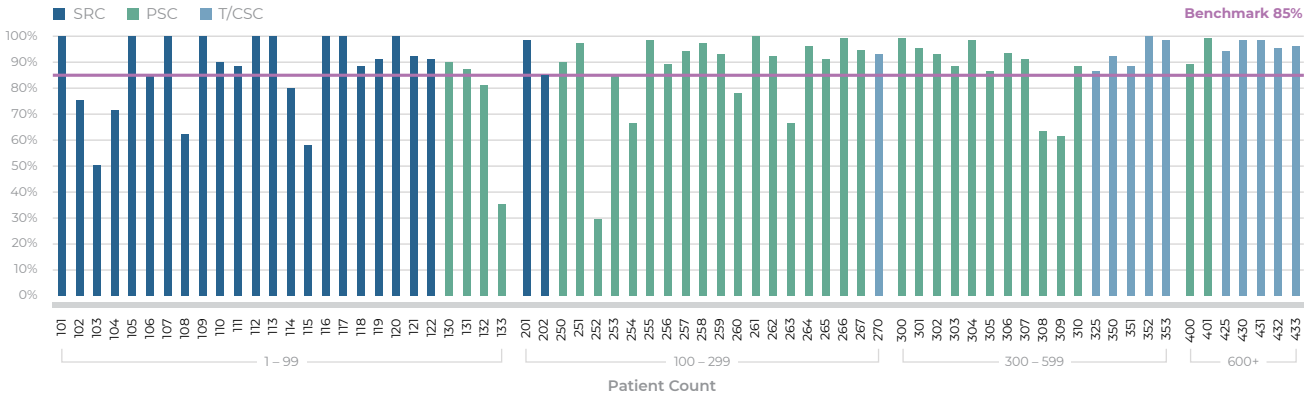
Best practice

Glucose is a required lab. If the patient has a blood clotting disorder, additional evaluation is necessary. Glucose point of care testing at the bedside is acceptable.

Comment

Four Stroke Ready Centers and one Primary Stroke Center missed this benchmark. Among those that met is, the average success rate was 97%.

SM-15: *Neuroimaging Studies*



Success rate: 80% of ACHC-certified programs met or exceeded the benchmark.*

Comparison to past performance: ↑ improvement from 77% in 2023.

What is being measured?

The percentage of patients exhibiting or presenting with acute stroke symptoms (as defined by hospital protocols) for whom neuroimaging (CT scan or MRI) turnaround time (TAT) with results reported to the provider occurred within 45 minutes of arrival.

Relevant Standard: 02.00.04 for all programs..

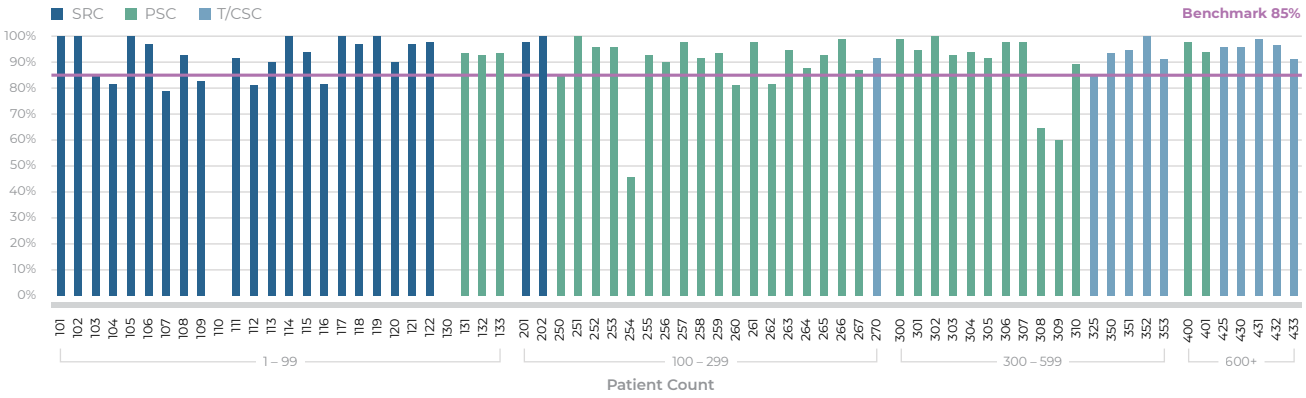
Best practice

Every minute counts and this measure directly impacts SM-12 Door-to-Needle. Neuroimaging turnaround is measured from patient arrival until the qualified provider has received results of the scan. Ensure processes are setup for rapid patient assessment and decision to scan. Prioritize all aspects of CT scanning for stroke patients from clearing the table to rapid radiologist read and communication of results. Break down your process steps to determine where minutes are being used that may create delays in TAT.

Comment

Six Stroke Ready Centers and seven Primary Stroke Centers missed the benchmark with scores ranging from 27% to 81% with an average of 62%. For those that met the benchmark, the average score was 94%.

SMA-1: *NIHSS for Ischemic Stroke*



Success rate: 86% of ACHC-certified programs met or exceeded the benchmark.

Comparison to past performance:
= 100% in 2023 for Thrombectomy/Comprehensive Stroke Centers. This is the first year that results are reported Stroke Ready and Primary Stroke Centers.

What is being measured?

The percentage of ischemic stroke patients for whom a National Institutes of Health Stroke Scale (NIHSS) examination is performed and documented in the medical record prior to any acute recanalization therapy (i.e., tPA/TNK therapy or mechanical endovascular reperfusion therapy) or for whom an initial NIHSS assessment is documented within 12 hours of ED arrival for patients who do not undergo recanalization therapy.

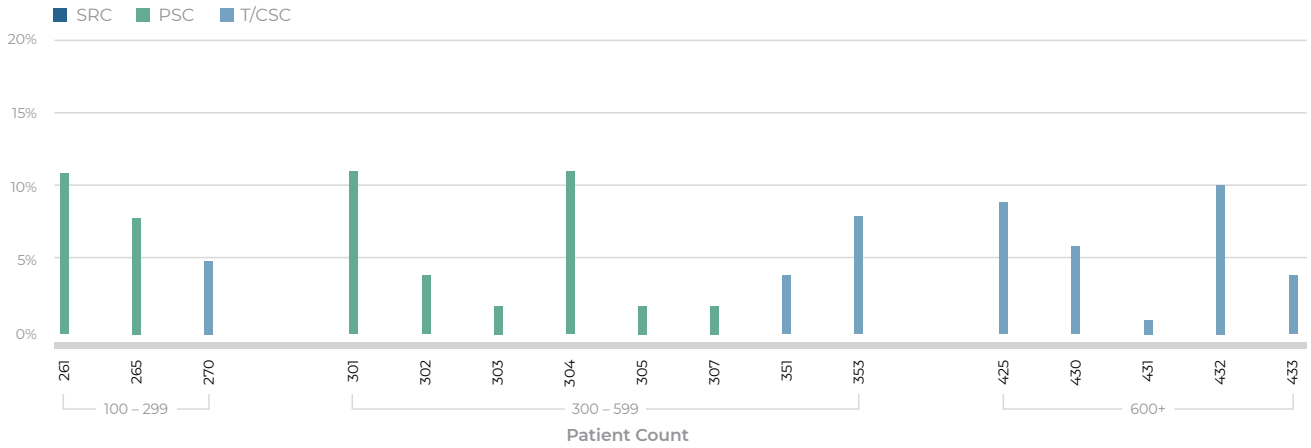
Best practice

Used as a data collection tool for planning patient care, the NIHSS provides a common language for information exchange among providers. The 15-item examination evaluates the effect of acute cerebral infarction on the levels of consciousness, language, neglect, visual-field loss, extraocular movement, motor strength, ataxia, dysarthria, and sensory loss.

Comment

Five Stroke Ready Centers and five Primary Stroke Centers missed the benchmark. This measure was added for these program levels with the ACHC Certification Standards that became effective in August 2024. The data covered in this report represents the first full year of data for all ACHC Stroke Certification programs.

SMA-5: *Hemorrhagic Transformation*



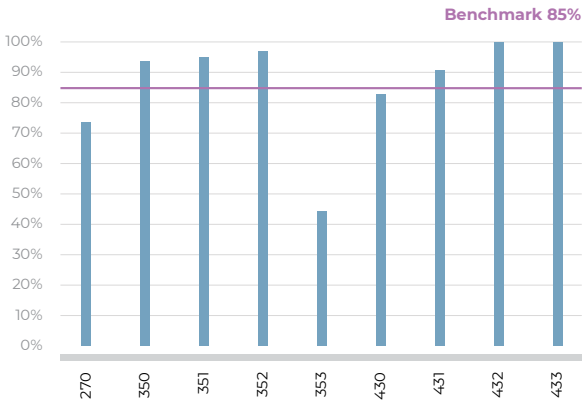
What is being measured?

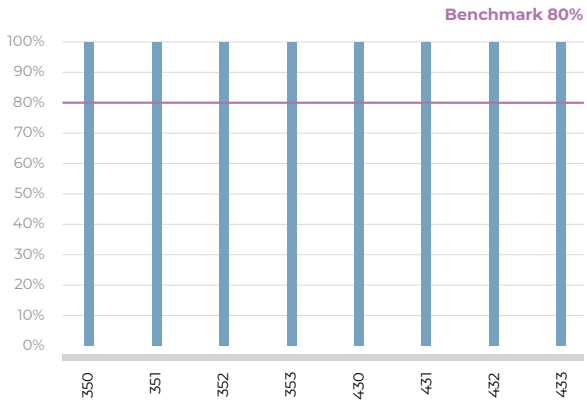
The percentage of ischemic stroke patients who develop a symptomatic intracranial hemorrhage (i.e., clinical deterioration ≥ 4 point increase on NIHSS and brain image finding of parenchymal hematoma, or subarachnoid hemorrhage, or intraventricular hemorrhage) within the 36 hours of the start of treatment with IV or IA thrombolytic (tPA/TNK) therapy, or mechanical endovascular reperfusion procedure (i.e., mechanical endovascular thrombectomy with a clot retrieval device).

Comment

Primary, Thrombectomy, and Comprehensive Stroke programs report on this measure which has no associated benchmark. The metric is used for tracking and trending with the goal that this complication would be rarely seen. The chart depicts only those hospitals with a result greater than 0%.

The following performance measures focus on assessment and interventions specific to Thrombectomy and Comprehensive Stroke Centers.





SMA-3: Severity Measure Performed for SAH and ICH

What is being measured?

The percentage of subarachnoid hemorrhage (SAH) and intracerebral hemorrhage (ICH) stroke patients for whom a severity measurement (e.g., Hunt and Hess Scale for SAH patients or ICH Score for ICH patients) is performed and documented in the medical record prior to clipping, coiling, or any surgical intervention or within six hours of arrival at the hospital ED for patients who do not undergo surgical intervention.

Comment

A standardized clinical classification system ensures all providers are using consistent language. A classification measure helps guide management decisions that may be influenced

by the severity of the SAH/ICH and supports a prognosis for clinicians, patients and family.

Two hospitals did not report on this measure and three reporting facilities missed the benchmark in 2025 reporting. The overall average for all reporting hospitals was 87%.

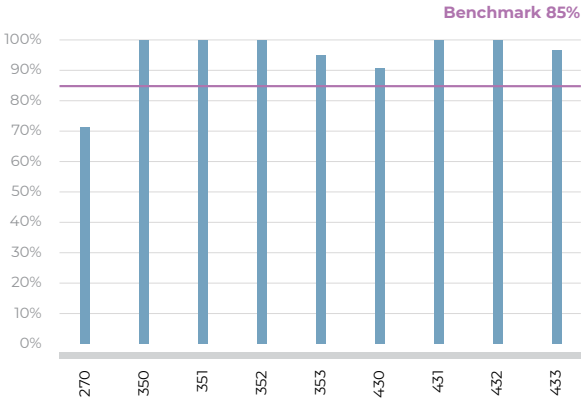
SMA-4: Procoagulant Reversal Agent Initiated for ICH

What is being measured?

The percentage of intracerebral hemorrhage (ICH) stroke patients with an INR value > 1.4 at hospital arrival who are treated with a procoagulant reversal agent (i.e., fresh frozen plasma, recombinant factor VIIa, prothrombin complex concentrates).

Comment

All hospitals reported 100% use of a procoagulant reversal agent for applicable patients.



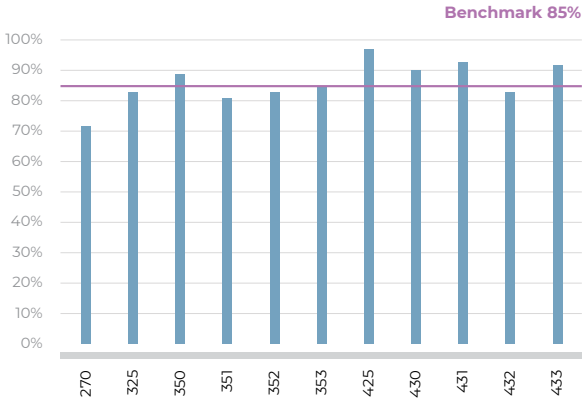
SMA-6: Nimodipine Treatment Administered

What is being measured?

The percentage of subarachnoid hemorrhage (SAH) patients for whom nimodipine treatment was administered within 24 hours of hospital arrival.

Comment

In 2025, all but one reporting stroke programs exceeded the threshold of 85%, with an average performance score of 98%.



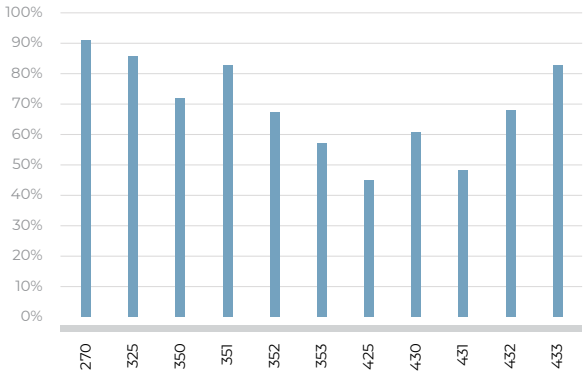
SMA-8: Thrombolysis in Cerebral Infarction

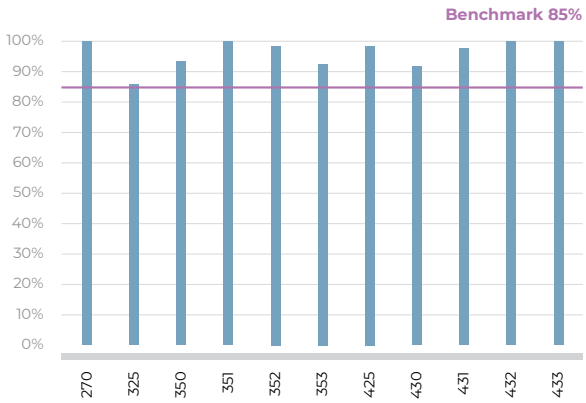
What is being measured?

The percentage of ischemic stroke patients with a post-treatment reperfusion grade of TICI 2B or higher in the vascular territory beyond the target arterial occlusion at the end of treatment with intra-arterial (IA) thrombolytic (tPA/TNK) therapy and/or mechanical endovascular
reperfusion therapy.

Comment

Only 45% of the reporting hospitals achieved the benchmark for this metric with scores ranging from 72% to 83%. Those that achieved the benchmark averaged 91%.





SMA-9: Door-to-Skin Puncture Time

What is being measured?

The percentage of acute ischemic stroke patients for whom the goal of < 90 minutes from hospital arrival to the time of skin puncture to access the artery (e.g., brachial, carotid, femoral, radial) selected for endovascular treatment (EVT), (i.e., tPA/TNK therapy and/or mechanical embolectomy devices).

Comment

The benchmark for this measure is defined by each hospital. The average achievement for artery access in fewer than 90 minutes from arrival time was 69%. This is a lower average than 72% reported in 2023.

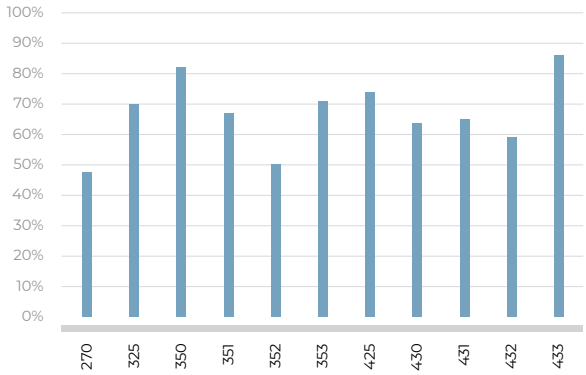
SMA-10: Modified Rankin at Discharge

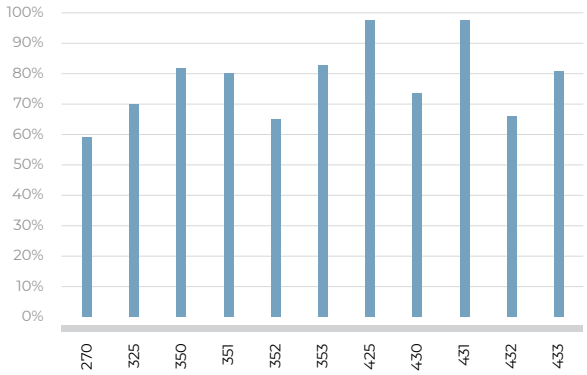
What is being measured?

The percentage of ischemic stroke patients treated with IV or IA thrombolytic (tPA/TNK) therapy or who undergo mechanical endovascular reperfusion therapy for whom a Modified Rankin Score (mRS) is obtained at discharge.

Comment

All organizations achieved the benchmark with an average performance of 96%.





SMA-11: Timeliness of Reperfusion: Arrival to TICI 2b or Higher

What is being measured?

The percentage of ischemic stroke patients who have large vessel occlusion in the internal carotid artery (ICA) or ICA terminus, middle cerebral artery (MCA) M1 or M2, or basilar artery, and who receive mechanical endovascular reperfusion therapy within 120 minutes of hospital arrival and achieve TICI 2b or higher at the end of treatment.

Comment

This is another metric for which each hospital is expected to establish its own goal. This cohort of reporting hospitals achieved the measure within the time frame for 67% of patients.

SMA-12: Timeliness of Reperfusion: Skin Puncture to TICI 2b or Higher

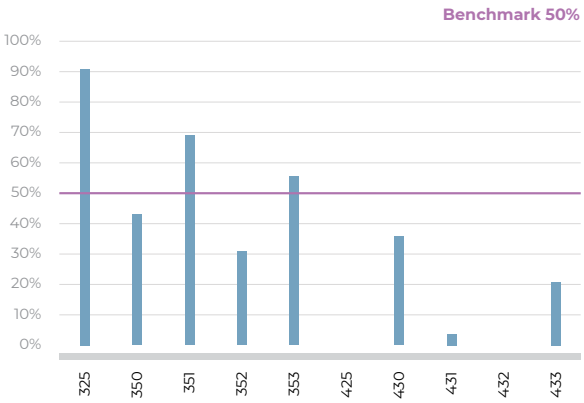
What is being measured?

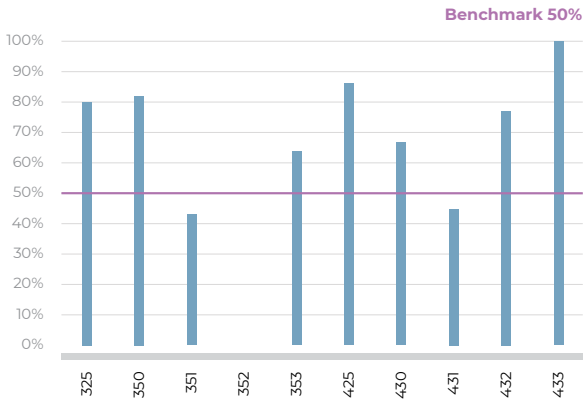
The percentage of ischemic stroke patients who have large vessel occlusion in the internal carotid artery (ICA) or ICA terminus, middle cerebral artery (MCA) M1 or M2, or basilar artery and who receive mechanical endovascular reperfusion therapy and achieve TICI 2b or higher in 60 minutes or less from time of skin puncture.

Comment

This measure is a refinement of SMA-11, looking at the window from arterial access to achievement of partial restoration of blood flow to the affected brain territory. While historically considered a successful outcome, a higher measure of reperfusion (TICI 3/2c) is increasingly associated with better functional outcomes.

The benchmark here is defined by each hospital and the average percentage for 60 minute achievement of TICI 2b or higher was 78%.





SMG-1A: Door to First Pass or Device Time in 90 Minutes

What is being measured?

The percentage of acute ischemic stroke patients who arrive within 24 hours of time last known well or symptom discovery who receive mechanical endovascular reperfusion therapy and for whom the first deployment of the device is within 90 minutes of arrival for patients presenting through the ED.

Comment

Only 27% of reporting hospitals achieved the benchmark for this measure. Two hospitals were outside the 90 minute time frame all eligible patients.

SMG-1B: Door to First Pass or Device Time in 60 Minutes for Transferred Patients

What is being measured?

The percentage of acute ischemic stroke patients who are transferred from another hospital, arriving within 24 hours of time last known well or symptom discovery who receive mechanical endovascular reperfusion therapy within 60 minutes of arrival.

Comment

In 2025, 70% of reporting hospitals met the benchmark. The denominators for this metric tend to be small, so any patients treated outside the 60-minute goal will have a significant impact on the resulting percentage. For those that missed the benchmark, the number of eligible patients spanned from one to 11.

17

CORE MEASURES*

11	2	3
SAW IMPROVEMENT FROM THE 2023 REPORT	DECLINED IN PERFORMANCE FROM 2023	REMAINED STEADY

*Core measures cross certification options. Nine are common to all levels. The remaining seven are required for Primary, Thrombectomy, and Comprehensive Stroke Centers. Thrombectomy Centers report on seven additional measures and Comprehensive Centers add three more for a total of 27.

Performance measures provides an objective measure of a stroke center's care delivery. Benchmarks represent professional consensus on achievable goals for specific elements of stroke care and associated timelines. But it's important to remember that the gap between goal achievement and 100% represents patient lives. This is why ACHC emphasizes continuous improvement efforts and strives to offer support in the form of education and collaboration among stroke centers.

ACHC will continue to provide midcycle reviews for Primary Stroke Centers, Thrombectomy Centers, and Comprehensive Stroke Centers. ACHC also will continue to provide quarterly stroke teleconferences. Our practice-sharing sessions have been well-received by stroke coordinators and hospital leadership. If you do not currently receive information to register for these programs and would like to, or if you have a topic you would like to present or propose for discussion, please let us know by emailing **certification@achc.org**.

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