Each year, close to 800,000 people in the U.S. suffer from a stroke. It is the top cause of long-term disability and the fourth leading cause of death, killing 140,000 Americans annually. Stroke awareness and treatment options have grown significantly in the past decade as a response to these frightening statistics.

Today, telestroke programs are part of the routine standard of care in many U.S. hospitals. By virtually connecting stroke specialists to patients, regardless of their locations, these hospitals have saved countless lives using time-sensitive treatments. But how did telestroke programs start? What is the history behind these life-saving initiatives?

In this article, we will introduce you to Georgia Regents University (GRU), an Augusta, Ga.-based academic health center and research university. GRU’s groundbreaking telestroke program, which started 11 years ago, has become a de facto model for telestroke programs at other hospital systems around the country. This article will take you through the program’s evolution and show you how GRU has helped change the way stroke patients are treated today.

Georgia Regents University: Evolution of One of the Country’s Longest-Running Telestroke Programs

To date, the GRU telestroke network has grown to 29 hospitals located across Georgia and has conducted more than 4,000 remote consultations. Administration sites for telestroke have increased throughout the state, significantly improving positive outcomes for ischemic stroke patients.

In fact, Dr. Hartmut Gross, a GRU neurologist, has conducted more than 600 remote consultations — not only from GRU, but also from home and in one case, from a computer store! Dr. Gross was paged by a rural hospital about a potential stroke victim. The doctor, with the help of the store manager, set up the two-way audio and video connection on a computer at the back of the store and was able to diagnose the patient with minimal delay.

GRU’s groundbreaking telestroke model is now replicated at other healthcare networks throughout the country. To date GRU’s telestroke network has expanded from one college to its current 29 hospitals, offering coverage for patients dealing with other nervous system issues.

To date, the telestroke program extends into urban and suburban community hospitals - improving how these hospitals manage stroke patients and treatments.

Successes and Future Plans

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Timeline of the Georgia Regents University Program

1990: Great Leap Forward for the Treatment of Stroke

In 1990, the Food & Drug Administration (FDA) approved intravenous tissue-type plasminogen activator (tPA) to dissolve blood clots in疏通 stroke patients. The approval was a significant step in improving patient care. The new drug had been shown to significantly help a large percentage of stroke victims.

1996: The FDA Approves tPA

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1999: GRU Launches Telestroke Program

As the “hub,” GRU would connect to the rural hospital “spokes” and kick off a hub-and-spoke-based telestroke program in 2003. GRU was tasked with providing critical services to a large geographic area, including rural and underserved populations. GRU had a growing network and was looking to strengthen its neurology coverage and improve patient care. GRU launched its own telestroke program, which was the first of its kind in the region.

2002: GRU Launches Telestroke Program

In 2002, a group of doctors at GRU (formerly known as the Medical College of Georgia) came together to develop a new approach for stroke patients in the Augusta region. The doctors were looking to improve patient care and strengthen their neurology coverage. They wanted to stay ahead of this change, so they made the decision to launch their own telestroke program.

2003: GRU Launches Telestroke Program

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2004: Program Maturity and Growth

With the GRU telestroke program in place, rural hospitals could improve their stroke care. GRU was able to provide critical services to a large geographic area, including rural and underserved populations. GRU had a growing network and was looking to strengthen its neurology coverage and improve patient care. GRU launched its own telestroke program, which was the first of its kind in the region.
provide consultations with stroke specialists via video and audio. As the "hub," GRU would connect to the rural hospital "spokes" and make treatment decisions based on very little information. The stroke patients admitted to GRU were initially seen at an outside facility – causing a time gap that often negated the opportunity for the use of tPA. The reason for this was the time-sensitive nature of the medication and the general lack of access to stroke specialists to make real-time treatment decisions; the use of tPA was minimal for several years.

Despite having a world-class stroke team, GRU was treating less than one patient per month with tPA. The reason for this was the obvious benefits of the medication, the vast majority of hospitals were not functioning as telestroke programs

In 2002, a group of doctors at GRU (formerly known as the Medical College of Georgia) came together to rethink treatment options for stroke victims. How it Worked – Trial and Error at the Start

As one of the first telestroke programs of its kind, GRU didn’t have a proven model, but were looking to strengthen their neurology coverage and zoom camera controls, and two-way audio was provided via telephone. The doctors could answer those calls and log on to see the patient, regardless of where they were located. GRU had the ability to see and treat patients close by and far away, which could be faulty at times, the telestroke program flourished in its first few years with major improvements to clinical care.

At GRU, the technology was simple. It provided stroke specialists with more information so that treatment decisions could be made in a timely fashion. Despite a limited staff and technology that simply lacked around-the-clock stroke coverage and improved patient care. The expansion of the telestroke network resulted in the need for more sophisticated telemedicine technology, workflows and agitation. GRU lacked the sophistication of technology and resources to help make its vision a reality. In the early 2000s, telemedicine was not the sophisticated industry that it is today, so GRU had to turn to help make its vision a reality. In the early 2000s, telemedicine was not the sophisticated industry that it is today, so GRU had to turn to help make its vision a reality. In the early 2000s, telemedicine was not the sophisticated industry that it is today, so GRU had to turn to help make its vision a reality. In the early 2000s, telemedicine was not the sophisticated industry that it is today, so GRU had to turn to help make its vision a reality. In the early 2000s, telemedicine was not the sophisticated industry that it is today, so GRU had to turn to help make its vision a reality.

During the next few years, GRU added several of these larger facilities were small, some critical access hospitals, and all of them offered 24-hour coverage. As a solution, the hospital joined the GRU Telestroke program to provide neurology coverage at night.

Initially a hub-and-spoke network, GRU now refers to itself as a super spoke at work – St. Mary’s. GRU Telestroke Network (2009-2012) GRU Telestroke Network (2013-2014)

GRU Telestroke Network (2009-2012)

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and, if appropriate, treat stroke patients with tPA faster at their local audiovisual connection and transmission of CT images to diagnose GRU looked to telemedicine to solve this problem – using an to this process as “tPA by Russian roulette.”

they often had to make treatment decisions based on very little and/or benefits of tPA. While GRU stroke specialists would sometimes hospitals first and subsequently transferred to GRU. In fact, half of that many of their patients went to their rural, resource-strapped Despite having a world-class stroke team, GRU was treating less stroke patients in the Augusta region.

In 2002, a group of doctors at GRU (formerly known as the Medical College of Georgia) came together to rethink treatment options for stroke patients in the Augusta region.

While the internal system was simple, it provided GRU’s stroke-specialists with more information so that treatment decisions could be made in a timely fashion. Despite a wide array of technology and cameras, the carts had a one-way video connection with camera, and another way audio was provided via a wireless phone. GRU also developed an all-inclusive support for the telestroke program and had a very limited network. The doctors could determine their thoughts and advice to join the network.

The evolution was likely driven by development of designated Primary Stroke Centers, increasing the focus on hospitals to provide for all potential candidates. At the same time, there were still widespread disconnect among emergency department physicians around the administration of tPA without the help of neurologists. Hospital administrators were convinced that if the telestroke program did not survive, it would be impossible to provide care for other patients. Additionally, many neurologists were burned away from in-hospital care, judging it a tough spot when telestroke workflow was needed more than ever.

During the first years, GRU added several of their larger hospitals, dubbed “super spokes,” to its network. These facilities were based across Georgia and many were Primary Stroke Centers, that simply backed up the other stroke programs and required that the same acute coverage be provided at rural hospitals sought.

How It Worked – Expansion in Motion

With the GRU telestroke program initially was created to work with rural, resource-strapped hospitals,格鲁 had to change in order to become a rapid community options and local hospitals and allow physicians to capture their thought, treatments and advice, as one system.

While GRU still had no coordinator for the program, GRU now provided all of the IT support, allowed the number of care locations increased from three to five. GRU required that larger spoke hospitals fund their own carts and IT support and began charging hospitals $24 per hour.

As of 2013, GRU had connected with 44 hospitals and had out of the 2013-2014 GRU Telestroke Network (2009-2012)
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GRU’s groundbreaking telestroke model is now replicated at other healthcare networks throughout the country. In fact, 85% of GRU’s telestroke consultations are becoming standard of care for ischemic stroke patients when every second counts.

And the hospital has no plans to slow down, finding new ways to use telemedicine to overcome distance barriers and facilitate the continuity of care. GRU plans to continue its telestroke program in urban and suburban community hospitals - improving how these hospitals manage stroke patients and treatments.

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Today, the telestroke program extends into urban and suburban community hospitals—improving how these hospitals manage stroke patients and treatments. The telestroke program has evolved to provide faster treatments and reduce readmission rates.

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Inside:
How GRU leads the nation in stroke telemedicine

Telemedicine advancements to meet patient and hospital needs

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