NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

2025 STROKE REGISTRY DATA SUMMARY

State of Nevada

Department of Human Services

Division of Public and Behavioral Health

Chronic Disease Prevention and Health Promotion Section

Joe Lombardo

Governor

State of Nevada

Andrea R. Rivers, MS

Administrator

Division of Public and Behavioral Health

Laura Rich

Director

Department of Human Services

Ihsan Azzam, PhD, MD

Chief Medical Officer

Division of Public and Behavioral Health

Prepared by: Troy Lovick, MS, NR-P
Cardiovascular Health Program Coordinator
Chronic Disease Prevention and Health Promotion Section
Nevada Division of Public and Behavioral Health

Acknowledgments

The Division of Public and Behavioral Health expresses sincere appreciation to the following individuals and organizations for their contributions to this report and to Nevada's cardiovascular health efforts.

Nevada DPBH Staff

Vickie Ives, MA, Bureau Chief, Child Family Community Wellness (CFCW)

Sarah Rogers, Deputy Bureau Chief, CFCW

Amber Hise, RD, Section Manager, Chronic Disease Prevention and Health Promotion (CDPHP)

Michelle Harden, PhD, MPA, Quality Assurance Manager, Chronic Disease Prevention and Health Promotion (CDPHP)

Godwin Nwando, MPH, PhD (c), Community Wellness Unit Manager, Chronic Disease Prevention and Health Promotion (CDPHP)

Contributing Partners

Access to Healthcare Network (AHN)

Nevada Office of Minority Health and Equity (NOMHE)

The Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease (CWCD)

Data Partners

Nevada Health Authority, Office of Analytics

American Heart Association, Get With The Guidelines®-Stroke Data Registry

Centers for Disease Control and Prevention, Paul Coverdell National Acute Stroke Program and Behavioral Risk Factors Surveillance Survey

Nevada Department of Taxation, Population Estimates

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Data Sources

This report draws from four primary data sources:

- ✓ Nevada Hospital Billing Data (HBD) accessed through the Office of Analytics
- ✓ The Get With The Guidelines®-Stroke (GWTG-S) / Paul Coverdell National Acute Stroke Program quality registry.
- ✓ The Behavioral Risk Factor Surveillance System (BRFSS)
- ✓ Governor-certified population estimates from the Nevada Department of Taxation (NRS 360.283).
- ✓ Data reflect calendar year 2024 unless otherwise noted.

Executive Summary

The 2025 Nevada Stroke Registry Data Summary, prepared by the Division of Public and Behavioral Health (DPBH) Cardiovascular Health Program, presents a comprehensive analysis of stroke incidence, prevalence, and care quality across Nevada using calendar year 2024 data. This report fulfills the mandates of Nevada Revised Statutes (NRS) 439.5291 through 439.5297, inclusive, and serves as a resource for policymakers, healthcare partners, and the public.

2024 DATA AT A GLANCE

9,064
Stroke Cases
Nevada residents, 2024 a 5-year high

4.10%
Adult Stroke Prevalence
Nevada vs. 3.53% nationally (BRFSS, 2024)

+139%
Rise in AIAN Stroke Rate
American Indian/Alaska Native, 2020–2024

481.4
Age-Adjusted Rate, Black
Per 100,000 — highest of any group, 2024

~80%
of Strokes Are Preventable
Representing thousands of avoidable cases annually

Key Findings

Nevada recorded 9,064 stroke cases among state residents in 2024, the highest total in the five-year period spanning 2020 through 2024. Clark County, home to nearly three in four Nevadans, accounted for 6,721 cases, while Washoe County contributed 1,211. The persistence of elevated case counts ranging from 8,594 in 2020 to the 2024 peak signals an ongoing and escalating public health burden requiring sustained, coordinated intervention.

Adult stroke prevalence measured by the Behavioral Risk Factor Surveillance System (BRFSS) has climbed steadily, reaching 4.10%, compared to 3.53% nationally. Nevada has exceeded the national prevalence rate in four of the five-years in the trend period. The state also carries a disproportionately high burden across other chronic conditions closely linked to stroke risk, including diabetes 14.6% vs. 13.4% nationally and Chronic Obstructive

Pulmonary Disease (COPD) 6.5% vs. 6.3%, underscoring the need for integrated, whole-patient approaches to cardiovascular disease prevention.

A notable finding in this report is the sustained elevation of stroke among Nevada's American Indian and Alaska Native (AI/AN) population. The age-adjusted stroke rate for this group has remained consistently high since 2021, ranging from 186.7 to 235.5 per 100,000, and reached its highest level in 2024. As of 2024, the AI/AN rate exceeds the rate among White Nevadans (208.5 per 100,000), a reversal from earlier in the period and an indication that this gap is worsening rather than improving. Black Nevadans continue to carry the highest overall age-adjusted rate at 481.4 per 100,000, more than double the rate of White Nevadans.[1]

Hospital quality data from Nevada's 16 participating GWTG-S / Coverdell program hospitals show consistent adherence to key performance measures, with statewide rates exceeding 93% for rehabilitation consideration, antithrombotic therapy at discharge, and early antithrombotic administration. However, the time-to-treatment measure for intravenous thrombolytic therapy within 45 minutes of arrival, a critical window for minimizing brain damage, stands at 60.8% statewide. This gap represents a clear opening for quality improvement initiatives.

Elko County illustrates that structured stroke care is achievable in rural Nevada. Northeastern Nevada Regional Hospital holds an Acute Stroke Ready designation and maintains a tele-stroke partnership with the University of Utah, providing stroke patients with rapid evaluation and stabilization close to home during the initial treatment window.

On the prevention side, Nevada's Heart Healthy Ambassador Blood Pressure Self-Monitoring (HHA-BPSM) program, delivered in partnership with Access to Healthcare Network, demonstrated sustained effectiveness across 21 months of operation. Among 147 participants, 93% identify as being from medically underserved communities where rates of poorly controlled blood pressure often exceed those in well-resourced populations. The program achieved a mean blood pressure reduction of 8.4/7.4 mmHg, translating to an estimated 20–25% reduction in stroke risk. The program's 78% growth from Year 1 to Year 2, with maintained completion rates and clinical outcomes, establishes it as a scalable, replicable model for community-based cardiovascular disease prevention.

> *The data indicates clear trends:*

[1] Age-adjusted rates for racial and ethnic groups with smaller population denominators, including American Indian and Alaska Native Nevadans, are subject to greater year-to-year variability than rates for larger population groups. The 2020 AI/AN rate of 98.5 per 100,000 is anomalously low relative to subsequent years. Trend analysis in this section anchors on the 2021 to 2024 period.

Nevada's stroke burden is high, rising, and unevenly distributed across Nevada's communities. Research indicates that approximately 80% of strokes are preventable[1] through management of modifiable risk factors.[14] The policy recommendations in this report identify evidence-based strategies aligned with these findings. The impact includes increases in healthcare expenditures, long-term disability, lost productivity, and greater caregiver burden.

Impact and Burden of Stroke in Nevada

National and State Context

Stroke, often called a "brain attack", occurs when blood flow to the brain is abruptly interrupted, causing brain cells to begin dying within minutes. Each minute without treatment results in the loss of approximately 1.9 million brain cells.[1] This rapid progression underscores why stroke is a medical emergency: Patients who arrive at the emergency room within 3 hours of symptom onset have less disability at 3 months compared to those who receive delayed care.[1] In the United States in 2024, stroke is the fifth leading cause of death and the number one cause of long-term serious disability.[2] About 800,000 Americans have a stroke each year, and more than 140,000 die from it. In Nevada, stroke is also the fifth leading cause of death, claiming an estimated 1,500 lives per year.[3]

800,000
Strokes occur annually in the United States

1,500
Estimated annual stroke deaths in Nevada

Stroke is a leading cause of serious long-term disability in the United States. More than half of stroke survivors aged 65 and older experience reduced mobility, and many face persistent deficits in speech, cognition, or physical function.[1] Family members frequently serve as informal caregivers, contributing uncompensated care. Stroke-related costs in the United States totaled nearly $56.2 billion between 2019 and 2020, including healthcare services, medications, and lost productivity [4]

Economic Burden

Stroke is one of the most expensive medical conditions in America. A stroke survivor costs the healthcare system roughly $4,317 more per year than a person without stroke history, adding up to $38 billion in direct medical costs nationally each year.[4] When lost work and early death are included, the total economic burden reaches $103.5 billion annually.[4]

$103.5B Total annual U.S. economic burden of stroke — $38 billion in direct medical costs plus $65.5 billion in lost productivity and premature mortality. (2016 USD)[4]

Nevada's share of this burden runs into hundreds of millions of dollars each year. The communities hit hardest are often those with the least access to preventive care, the same

communities where stroke rates are climbing fastest. Preventing a single stroke avoids an estimated $140,000 or more in lifetime medical costs alone.[5] Investing in prevention is a prudent financial decision.

Preventability - Nevada's Greatest Opportunity

The most important fact in this report is also the most hopeful: about 80% of strokes are preventable.[6,7] High blood pressure is the single biggest risk factor, playing a role in up to 90% of all strokes.[8] Other major risk factors including diabetes, high cholesterol, irregular heartbeat, obesity, smoking, and inactivity are all manageable with the right care and support.

~80%	of strokes are preventable, representing roughly 7,250 of Nevada's 9,064 stroke cases in 2024. Every improvement in risk factor control means fewer Nevadans having strokes, losing independence, or dying prematurely.[6,7]

Despite years of progress, stroke death rates have stopped improving, and for some groups, they are getting worse. Nevada's American Indian/Alaska Native population's stroke rate rose 139% in four years.

Stroke also does not affect all Nevadans equally. The people most likely to have a stroke are often those with the least access to preventive care.[9] Closing that gap could be the most effective strategy for reducing strokes across the entire state.

Nevada's Stroke Burden in Context

With 9,064 stroke cases in 2024,[8] Nevada's stroke burden is large and growing. The current trend data suggest that these rates may continue to increase absent focused intervention. The sections that follow detail the underlying patterns and identify evidence-based strategies to address them.

Stroke Prevalence BRFSS Data

The Behavioral Risk Factor Surveillance System (BRFSS) is a nationwide telephone health survey conducted annually by the Centers for Disease Control and Prevention (CDC). It captures the percentage of adults who report ever having been told by a doctor that they had a stroke. BRFSS data complement hospital billing records by measuring stroke's long-term presence in the community, not just acute events.

Nevada vs. United States, Adult Stroke Prevalence, 2020–2024

Nevada's adult stroke prevalence has climbed steadily over the past five years, reaching 4.10% in 2024. That means roughly 1 in 24 Nevada adults are living with the effects of a stroke. Nevada has exceeded the U.S. average every year except 2021 in this trend period, and the gap is widening.

Year	Nevada	United States
2020	3.16%	3.15%
2021	3.19%	3.26%
2022	3.95%	3.57%
2023	3.86%	3.39%
2024	**4.10%**	**3.53%**

Figure 1. Adult stroke prevalence, Nevada vs. United States, 2020–2024. Source: CDC BRFSS.

The increase in Nevada's stroke prevalence combined with a peak in 2022 followed by a partial dip and renewed rise in 2024 points to both an aging population and the growing share of Nevadans living long-term with stroke-related disability. This structural trend underscores the need for long-term prevention measures.

Prevalence by Race and Ethnicity, Nevada, 2024

Stroke does not affect all Nevadans equally. Black Nevadans have the highest adult stroke prevalence at 5.98%, nearly twice the rate of Hispanic/Latino Nevadans 2.98%, and well above the state average. Asian and Pacific Islander Nevadans have the lowest measured

prevalence at 0.80%. American Indian/Alaska Native data are suppressed in the 2024 BRFSS due to low survey response rates, but age-adjusted hospitalization data in this report show their rates rising sharply.

Race / Ethnicity	Adult Stroke Prevalence (Nevada, 2024)	Percent %
Black / African American		5.98%
non-Hispanic White		4.63%
non-Hispanic Other		4.63%
Hispanic / Latino		2.98%
Asian / Pacific Islander		0.80%
AI/AN		Suppressed *

*Figure 2. Adult stroke prevalence by race/ethnicity, Nevada, 2024. Source: CDC BRFSS. *AI/AN data suppressed due to low response rate; see OAA registry data for hospitalization rates.*

These patterns reflect gaps in access to preventive care, risk factor management, and timely treatment. Uncontrolled hypertension, the leading cause of stroke, remains more prevalent in communities facing barriers to routine care. Reducing Nevada's stroke burden starts with reaching those communities with effective blood pressure management.

Chronic Disease Co-Morbidities Nevada vs. United States, 2024

Stroke rarely happens in isolation. It shares risk factors, high blood pressure, diabetes, obesity, and inactivity with other chronic conditions.[9] Nevada's chronic disease profile helps explain why its stroke rate is above average. Nevadans have higher rates of diabetes and COPD compared to the national average, both of which raise stroke risk. Understanding this overlap is key to designing prevention programs that address multiple conditions at once.

Condition	Nevada	U.S.	Difference	Context
Stroke	**4.10%**	3.53%	**+0.57%**	*Nevada exceeds national rate 2022–2024*
Diabetes	14.59%	13.35%	**+1.24%**	*Major modifiable stroke risk factor*
Arthritis	26.87%	26.55%	**+0.32%**	*Similar to national — population aging driver*
COPD	6.47%	6.30%	**+0.17%**	*Slightly elevated — tied to smoking rates*
Heart Disease	4.03%	4.31%	**-0.28%**	*Below national average*
Cancer	10.16%	11.82%	**-1.66%**	*Below national average*

Figure 3. Prevalence of selected chronic conditions, Nevada vs. United States, 2024. Source: CDC BRFSS. Positive difference (red) = Nevada higher than U.S.; Negative (green) = Nevada lower.

Nevada's elevated diabetes prevalence, 14.59% versus 13.35% nationally is notable. Diabetes roughly doubles the risk of stroke, and diabetic patients who have a stroke face worse outcomes and higher recurrence rates. Programs that address diabetes prevention and management are, in effect, also stroke prevention programs.

What the Prevalence Data Indicate

More Nevadans are living with stroke than ever before, and the burden falls hardest on Black Nevadans and, per hospitalization data, on American Indian/Alaska Native Nevadans. Nevada's elevated rates of diabetes and other co-occurring conditions mean that stroke prevention efforts must be broad-based and community centered. The next section examines how Nevada hospitals are performing in relation to stroke.

Types of Stroke

Not all strokes are the same. The specific stroke a person experiences determines appropriate treatment and how quickly it must begin. Understanding the four main types helps explain why the quality measures in the next section exist and why speed of care is so critical across all of them.

Type / Share of Cases*	What It Is and Why It Matters	Key Urgency Note
~70% **Ischemic Stroke** *ICD-10: I63*	Caused by a blood clot blocking an artery that supplies blood to the brain. This is the most common type of stroke. Without treatment, brain cells begin dying almost immediately. The clot-dissolving drug tPA is the primary emergency treatment when given quickly enough. **Primary treatments:** tPA (if eligible within 4.5 hrs.), thrombectomy for large vessel blockage, Antithrombotics, and statins	Every minute counts — time is brain.
~15% **Transient Ischemic Attack (TIA)** *ICD-10: I45.9 / G45*	Often called a "mini stroke," a TIA is caused by a temporary blockage that clears on its own. Symptoms resolve within minutes to hours, but a TIA is a serious warning sign. About 1 in 10 people who have a TIA will have a full stroke within 90 days, nearly half of those within 2 days. **Primary treatments:** Urgent evaluation, antiplatelets, blood pressure control, cardiac monitoring	A TIA is a medical emergency - do not wait.
~12% **Intracerebral Hemorrhage (ICH)** *ICD-10: I61*	Caused by a blood vessel bursting inside the brain, spilling blood into surrounding brain tissue. High blood pressure is the leading cause. ICH is generally more severe than ischemic stroke and carries a higher risk of death and lasting disability. tPA cannot be used — treatment focuses on controlling bleeding and reducing brain swelling.	**Highest mortality risk of all stroke types.**

	Primary treatments: Blood pressure control, reversal of blood thinners, surgical intervention in select cases	
~4% Subarachnoid Hemorrhage (SAH) *ICD-10: I60*	Caused by bleeding into the space between the brain and its surrounding membrane most often from a ruptured aneurysm. SAH often presents with a sudden, severe "thunderclap" headache. Although less common than other stroke types, SAH carries a significant risk of death or permanent brain injury if not treated immediately. **Primary treatments:** Neurosurgical or endovascular repair of the aneurysm, management of brain pressure	**Sudden worst headache of life = call 911.**

*Table 3. The four types of stroke: descriptions, ICD-10 classifications, and urgency notes. *Approximate share of cases based on national data and Nevada GWTG-S registry trends. Sources: American Heart Association. Heart Disease and Stroke Statistics — 2025 Update;13 Sacco RL, et al. An updated definition of stroke for the 21st century. Stroke. 2013;54(8).*[14]

Stroke Type Distribution in Nevada Participating Hospitals

Among Nevada's GWTG-S participating hospitals, ischemic stroke accounted for 70.4% of all cases in 2024. Transient ischemic attacks (TIA) comprised 14.9%, followed by intracerebral hemorrhage (ICH) at 12.1% and subarachnoid hemorrhage (SAH) at 4.4%.[10,11] This distribution closely mirrors national patterns.

Stroke Type	Share of Nevada GWTG-S Cases (2024, most recent by type)	%
Ischemic Stroke		70.4%
Transient Ischemic Attack (TIA)		14.9%
Intracerebral Hemorrhage (ICH)		12.1%
Subarachnoid Hemorrhage (SAH)		4.4%

Figure 4. Stroke type distribution among Nevada GWTG-S / Coverdell participating hospitals, 2023 (most recent type-specific data available). Source: AHA GWTG-S Registry / CDC Paul Coverdell National Acute Stroke Program. [10,11]

TIA: A Warning That Must Not Be Missed

Because TIA symptoms resolve on their own, many people do not seek emergency care or are sent home without adequate follow-up. This is a critical missed opportunity. Studies show that urgent evaluation and treatment after a TIA reduces the 90-day stroke risk by up to 80%.[15] Nevada's 14.9% TIA share represents thousands of patients each year who have received a warning signal. How those patients are managed in the hours and days after the event directly determines whether they go on to have a full stroke.

Why Stroke Type Determines Treatment

Within this report, the terms tPA and Alteplase are used interchangeably. tPA (tissue plasminogen activator) is a generic label for the clot-dissolving medication used as the frontline treatment for ischemic stroke, Alteplase is the most commonly used brand-name formulation in clinical practice.

The most important implication of stroke type is treatment eligibility. tPA, the clot-dissolving medication tracked by GWTG-S quality measures is used only for ischemic stroke. Giving tPA to a hemorrhagic stroke patient would worsen bleeding and be life-threatening. This is why accurate, rapid stroke diagnosis through brain imaging (CT scan) is a prerequisite. For tPA treatment it is not enough to know if a patient is having a stroke; clinicians must confirm the type before treatment begins.

This diagnostic requirement is built into the time pressure tracked by the tPA quality measures. The clock starts when the patient arrives, imaging must be completed, results reviewed, and the treatment decision made all within 45 to 60 minutes for the highest standard of care. Understanding stroke type also informs long-term secondary prevention: ischemic stroke patients receive antiplatelets and statins,[13] while hemorrhagic stroke patients require intensive blood pressure management and, in some cases, surgical intervention. [13,14]

What the Stroke Type Data Indicate

Seven in ten strokes in Nevada are ischemic, treatable with tPA if patients arrive quickly and hospitals act fast. One in seven are TIAs a warning sign that, if acted on urgently, offers a major opportunity to prevent the full stroke that follows. The next section examines where those patients are coming from and where gaps in the system exist.

County-Level Data Spotlight

Stroke does not affect every community equally and county level data reveals a story that statewide averages can conceal. Nevada's 9,064 stroke cases in 2024 were primarily concentrated in its most populous counties, but they also affect every part of the state, including rural communities where access to stroke care faces significant limitations.

Statewide 5-Year Case Trend, 2020–2024

Nevada's total stroke case count has fluctuated over five years but reached its highest point in 2024 at 9,064 cases. After peaking in 2021, counts dipped in 2022 before rising again through 2023 and 2024. The overall direction is upward consistent with Nevada's growing and aging population.

Year	Total Nevada Stroke Cases	Count	Yr/Yr Change
2020		8,594	—
2021		9,206	+612
2022		8,702	-504
2023		8,891	+189
2024		**9,064**	+173

Figure 5. Total Nevada stroke cases, 5-year trend, 2020–2024. Source: Nevada DHHS, Office of Analytics, Hospital Billing Data (HBD). ICD-10-CM codes I60–I69.16

Stroke Cases by Resident County, 2024

The table below shows stroke cases by resident county for 2024, broken into emergency department (ED) visits and inpatient (IP) admissions. For most counties, inpatient admissions greatly outnumber ED-only visits, indicating that patients are being admitted for full inpatient stroke care locally. Where ED visits are high relative to inpatient admissions, it often reflects transfer to higher-level facilities for definitive care.

Resident County	Emergency Dept	Inpatient	Total Cases	ED as % of Total	Note
Clark	581	6,140	6,721	9%	
Washoe	175	1,036	1,211	14%	
Nye	60	213	273	22%	
Lyon	41	173	214	19%	
Carson City	28	174	202	14%	
Douglas	32	161	193	17%	
Humboldt	10	38	48	21%	
Churchill	3	57	60	5%	
Elko	**41**	24	**65**	**63%**	**⚠ ED > IP complex cases transfer to CSC**
Pershing	6	11	17	35%	
White Pine	9	6	15	60%	*ED exceeds IP monitor*
Lincoln	7	2	9	78%	*ED exceeds IP monitor*
Storey	3	4	7	43%	
Lander	3	9	12	25%	
Mineral	4	6	10	40%	
Esmeralda	1	3	4	25%	
Eureka	0	1	1	0%	*No ED stroke visits recorded*

Unknown	0	2	2	0%	*No ED stroke visits recorded*
Total	**1,004**	**8,060**	**9,064**	**11%**	Statewide 2024 total

Table 4. Stroke diagnosis by resident county, Nevada, 2024. ED = emergency department visits; IP = inpatient admissions. Source: Nevada DHHS, Office of Analytics, Hospital Billing Data (HBD). ICD-10-CM codes I60–I69.16 Population data: Nevada Department of Taxation, Governor-certified estimates (NRS 360.283), 2025.17

The Elko Situation - Local Care with a Regional Ceiling

Elko County recorded 41 emergency department stroke visits but only 24 inpatient admissions in 2024, a 63% ED-to-total ratio that stands out sharply against every other county in Nevada. Understanding this pattern requires understanding what stroke care in Elko looks like.

Northeastern Nevada Regional Hospital in Elko holds Acute Stroke Ready Hospital (ASRH) certification, a meaningful designation that enables the hospital to diagnose stroke, initiate time-sensitive treatments including tPA, and provide stabilizing care. Critically, Northeastern Nevada Regional Hospital operates a Tele-stroke partnership with the University of Utah Health, allowing Elko emergency physicians to consult in real time with University of Utah neurologists before and during treatment decisions. This is not a community without stroke care. It is a community where the level of stroke care available is defined by what an Acute Stroke Ready Hospital can provide.

⚠ THE ELKO SITUATION - LIMITED ACCESS TO HIGHER-LEVEL STROKE CARE

41 ED Visits (2024)	**24** Inpatient Admissions (2024)	**232+** Miles to Nearest Comp. Stroke Center

Transfer to a Comprehensive Stroke Center (CSC) is required when a stroke case falls outside the scope of care an ASRH is certified to provide. These include large vessel occlusion requiring mechanical thrombectomy, hemorrhagic strokes requiring neurosurgical intervention, and cases requiring prolonged neurological intensive care. For Elko residents, the nearest CSCs are located more than 230 miles away in the Salt Lake City area, and Reno, Nevada's closest CSC, is 292 miles distant.

Nearest Stroke Center	Location	Certification Level	Distance	Est. Drive

				Time
University of Utah Hospital	Salt Lake City, UT	Comprehensive Stroke Center	**232 miles**	~3 hr 20 min
Intermountain Medical Center	Murray, UT	Comprehensive Stroke Center	235 miles	~3 hr 15 min
Renown Regional Medical Center	Reno, NV	Comprehensive Stroke Center	292 miles	~4 hr 15 min

Table 5. Nearest Comprehensive Stroke Centers to Elko, Nevada, with driving distances and estimated travel times. Source: Facility certification data, Nevada DPBH, 2025.

A transfer from Elko to Salt Lake City adds a minimum of 3 hours and 15 minutes of ground transport time, during which the patient's brain continues to sustain damage. For cases where mechanical thrombectomy is indicated, the treatment window is typically 6 to 24 hours from symptom onset, depending on imaging criteria.[24] Every hour of transport delay narrows that window. Air transport shortens travel time significantly but is weather-dependent, costly, and not always available for critically ill patients.

Geography as a Stroke Risk Factor

Research confirms that rural stroke patients experience significantly longer times from symptom onset to treatment, lower rates of tPA administration, and worse functional outcomes than urban patients even when a local hospital is available.[18] Northeastern Nevada Regional Hospital addresses this challenge through its Acute Stroke Ready designation and tele-stroke partnership with the University of Utah, which provides real-time neurological consultation during the critical initial evaluation and stabilization period. This model represents the standard of care for rural stroke systems and aligns with American Heart Association recommendations for tiered stroke center networks.[1,2] By design, Acute Stroke Ready hospitals stabilize and initiate treatment, then transfer patients requiring higher-acuity interventions such as neurosurgery or comprehensive neurological intensive care to the nearest appropriate facility. The distance between Elko and the closest Comprehensive Stroke Center means that transfer times remain a factor in patient outcomes. Elko's tele-stroke model is a genuine strength: it enables real-time neurological consultation.

The high ED-to-inpatient ratio in Elko reflects this reality directly. Many patients are evaluated, stabilized, and treated via tele-stroke consultation receiving the best available care locally and then transferred to a CSC for higher-level intervention.

Other County Highlights

White Pine and Lincoln counties also show ED visits that are comparable to or exceed inpatient admissions — 9 ED vs. 6 IP and 7 ED vs. 2 IP respectively. Their small total case counts (15 and 9) limit statistical interpretation, but the pattern is consistent with rural Nevada's broader reliance on emergency stabilization and transfer rather than local inpatient stroke care. Sustained monitoring of these patterns is warranted as Nevada's rural population ages.

What the County Data Indicate

Elko has access to local stroke services, which provides residents with timely initial evaluation and care. Northeastern Nevada Regional Hospital's Acute Stroke Ready designation, along with its tele-stroke collaboration with the University of Utah, illustrates how smaller communities can connect with specialized expertise. Further reducing remaining gaps in the regional system, such as increasing comprehensive stroke center capacity closer to northeastern Nevada, refining air transport protocols, and sustaining tele-stroke infrastructure represents an ongoing coordination challenge that typically involves planning and resources at the state level.

Hospital Quality Measures GWTG/Coverdell Program

The Get With The Guidelines®-Stroke (GWTG-S) program, operated through the American Heart Association and aligned with the CDC Paul Coverdell National Acute Stroke Program, measures evidence-based care quality at participating hospitals. Sixteen Nevada hospitals contributed 2024 data. Measures reflect in-hospital stroke care from medication protocols and clot-busting treatment speed to patient education and discharge planning.[10,11]

Statewide Performance 2024

In 2024, Nevada's hospitals achieved statewide compliance above 93% on ten stroke quality measures tracked through the Get With The Guidelines-Stroke registry. These compliance rates are consistent with sustained institutional investment in systems of stroke care. Three time-to-treatment measures, all related to tPA delivery, fell below that threshold. These three measures represent the largest measurable variance from performance benchmarks and indicate where system-level process improvements may have the greatest effect on patient outcomes.

Quality Measure	Statewide Performance (% Compliant)	%	Eligible Patients
Rehabilitation Considered		**99.3%**	3,883
Antithrombotics at Discharge		**98.8%**	3,592
Early Antithrombotics (by Day 2)		**95.6%**	2,739
LDL Cholesterol Documented		**95.6%**	3,692
Intensive Statin Therapy		**94.9%**	3,423
Smoking Cessation Counseling		**94.6%**	653
Anticoagulation for AFib/Aflutter		**94.4%**	656
NIHSS Severity Score Documented		**93.6%**	3,547

VTE Prophylaxis	**93.7%**	3,949
Stroke Education Provided	**93%**	2,780
tPA: Arrive ≤3.5 hr, Treat ≤4.5 hr	**86.2%**	593
tPA Therapy within 60 Minutes of Arrival	**83.8%**	426
tPA Therapy within 45 Minutes of Arrival ◄	**60.8%**	393

Table 1. Statewide GWTG-S / Coverdell quality measure performance, Nevada, 2024 (N=16 hospitals). Sorted by performance. ◄ = measure below 75% threshold. Source: AHA GWTG-S Registry / CDC Paul Coverdell National Acute Stroke Program.[10,11]

≥ 90% Strong

75–89% Monitor

< 75% Needs Attention

Understanding the Quality Measures

Each of the 13 GWTG-S / Coverdell measures reflects a specific, evidence-based step in stroke care. The table below describes what each measure tracks and why it matters for patient outcomes.

Quality Measure	What It Measures — and Why It Matters
Anticoagulation for Atrial Fibrillation / Atrial Flutter	Patients with AFib or AFL who had a stroke face a high risk of another one. This measure tracks whether they received blood-thinning medication before leaving the hospital — a proven step to prevent recurrence.
Antithrombotics at Discharge	Anti-clotting medications reduce the risk of a second stroke. This measure tracks whether stroke patients received a prescription for these medications when discharged, ensuring they continue protection at home.
Early Antithrombotics (by End of Day 2)	Starting anti-clotting medication within the first two days of hospitalization helps prevent stroke from worsening or recurring. This measure tracks timely initiation of these

	medications during acute hospital care.
Intensive Statin Therapy at Discharge	High-dose statin medications lower cholesterol and reduce the chance of a second stroke or heart attack. This measure tracks whether eligible ischemic stroke patients were discharged with an intensive statin prescription.
tPA: Arrive by 3.5 Hours, Treat by 4.5 Hours	For clot-caused strokes, the clot-dissolving drug tPA can only be given within a limited time window. This measure tracks whether patients who arrived within 3.5 hours of symptoms were treated by the 4.5-hour deadline.
Smoking Cessation Counseling	Smoking significantly raises stroke risk. This measure tracks whether stroke patients who smoke were offered counseling or medication to help them quit before or at discharge — a direct prevention opportunity.
VTE Prophylaxis	Stroke patients are at risk of blood clots forming in their legs (venous thromboembolism or VTE) during bed rest. This measure tracks whether patients received preventive treatment — such as compression stockings or blood thinners — within the first two days.
NIHSS Severity Score Documented	The NIH Stroke Scale (NIHSS) is a standardized 11-item test that measures stroke severity from mild to severe. Documenting it at arrival guides treatment decisions and creates a baseline for tracking recovery.
LDL Cholesterol Documented	High LDL cholesterol is a major stroke risk factor. Documenting a patient's LDL level during hospitalization informs discharge medication decisions and helps establish a baseline for long-term cardiovascular management.
Stroke Education Provided	Patients who understand their condition are better equipped to recover and prevent recurrence. This measure tracks whether stroke patients and their caregivers received education on warning signs, medications, risk factors, and when to call for help.

Rehabilitation Considered	Rehabilitation — including physical, occupational, and speech therapy — is central to recovery. This measure tracks whether every eligible patient's rehabilitation needs were assessed and addressed before or at discharge.
tPA Therapy within 60 Minutes of Arrival	Getting the clot-dissolving drug tPA within one hour of hospital arrival limits brain damage. This 'door-to-needle' standard tracks whether eligible ischemic stroke patients received tPA within the 60-minute benchmark.
tPA Therapy within 45 Minutes of Arrival	The more demanding 45-minute tPA benchmark goes beyond the standard of care. Research shows each 15-minute reduction in treatment time meaningfully improves recovery and reduces disability. This measure tracks achievement of that accelerated goal.

Table 2. Plain-language descriptions of the 13 GWTG-S / Coverdell stroke care quality measures. Source: AHA GWTG-S Registry / CDC Paul Coverdell National Acute Stroke Program.[10,11]

The tPA Treatment Window - Nevada's Priority Improvement Area

Tissue plasminogen activator (tPA) is the primary clot-dissolving medication for ischemic stroke. When given quickly, tPA restores blood flow before permanent brain damage sets in. The faster it is given, the better the outcome.[16]

Nevada tracks two time standards: tPA within 60 minutes of hospital arrival (83.8% statewide) and the more demanding 45-minute benchmark (60.8%). The gap between them represents a concrete and addressable system-level challenge.

60.8%
tPA within 45 minutes

The Most Critical Gap in Nevada Stroke Care

Statewide, only 60.8% of eligible stroke patients received tPA within 45 minutes of hospital arrival — roughly 4 in 10 eligible patients did not receive the fastest possible treatment. Research shows that every 15-minute reduction in treatment time improves functional outcomes and reduces long-term disability. [12]

Research published in the Journal of the American Medical Association (JAMA) found that each 15-minute reduction in door-to-needle time reduces mortality, improves functional independence, and decreases disability rates at 90 days. [12] The 45-minute gap between Nevada's median and the national benchmark is influenced by factors including emergency medical services and emergency department workflows, stroke team activation, imaging

turnaround, and communication protocols. Published literature identifies each of these as modifiable through process standardization and workforce training. [12]

Areas of Strength

Nevada hospitals excel at the care processes that protect stroke patients during and after hospitalization. Rehabilitation consideration reached 99.3% statewide. Antithrombotic prescriptions at discharge were provided to 98.8% of eligible patients. Early Antithrombotics, statin therapy, LDL documentation, smoking cessation counseling, and VTE prophylaxis all exceeded 93%.

These results reflect sustained high-quality systems of care driven by Nevada's stroke care teams. The GWTG-S and Coverdell programs provide the data infrastructure that makes this accountability possible, and Nevada's participation in both is a public health asset worth protecting and expanding.

What the Quality Data Indicate

Nevada hospitals excel at the care processes that protect stroke patients' medications, rehabilitation, and education. The one critical gap is speed of tPA delivery. Closing that gap statewide is the single highest-impact quality improvement available today, and it is achievable. The next section examines stroke types and what they mean for treatment decisions.

Home Blood Pressure Monitoring

The Evidence Base

High blood pressure, (hypertension) is the single most important modifiable risk factor for stroke, contributing to up to 90% of all strokes[8] Yet for millions of Americans, hypertension is undetected, undertreated, or uncontrolled. One of the most effective tools for closing that gap is home blood pressure monitoring (HBPM) i.e., patients measuring their own blood pressure at home regularly between clinical visits.

The 2024 American Heart Association/American Stroke Association Guideline for the Primary Prevention of Stroke gives a Class I recommendation for HBPM as part of a comprehensive blood pressure management strategy.[8] A landmark meta-analysis by Tucker et al. (2017) found that HBPM combined with health coaching reduces systolic blood pressure by an average of 6–10 mmHg compared to usual care alone, a magnitude of reduction that translates directly to a meaningful reduction in stroke risk.[19] The 2023 AHA Scientific Statement on HBPM further confirmed that structured self-monitoring programs improve blood pressure control rates, medication adherence, and patient engagement in their own care.[20]

Community health worker (CHW) models have emerged as a particularly effective delivery mechanism for HBPM programs, especially in populations facing barriers to traditional clinic-based care.[21] CHWs provide culturally tailored education, help patients navigate the health system, and offer the personal connection that drives sustained engagement. For medically underserved communities where rates of poorly controlled blood pressure often exceed those in well-resourced communities.[22,23] CHW-led programs have demonstrated outcomes that clinic-based care alone has not achieved.

Nevada's HHA-BPSM Program

The Heart Healthy Ambassador Blood Pressure Self-Monitoring (HHA-BPSM) program represents Nevada's adaptation of the evidence base described above. Delivered in part through a partnership between the Nevada Division of Public and Behavioral Health (DPBH) and Access to Healthcare Network, the program uses CHWs, called Heart Healthy Ambassadors, to deliver structured blood pressure self-monitoring support over a 4-month intervention period.

Running from September 2023 through May 2025, the program served 147 participants across 13 cohorts in a 21-month evaluation period. Participants recorded twice monthly blood pressure measurements, once a month nutritional education on dietary approaches to stopping hypertension (DASH), medication adherence support, and empowerment to

talk to a provider about their results, all delivered in a culturally and linguistically appropriate setting.

Measure	Overall (n=147)	Year 1 (n=58)	Year 2 (n=103)
Participants	147	58	103
Cohorts	13	3	10
BP Measurements Taken	1,123	469	654
Completion Rate	75.2%	75.9%	74.8%
Mean Baseline SBP	137.9 mmHg	138.6 mmHg	137.5 mmHg
Mean Post-Program SBP	128.2 mmHg	128.7 mmHg	127.5 mmHg
Mean SBP Reduction	**−8.4 mmHg**	**−10.0 mmHg**	**−7.5 mmHg**
Mean DBP Reduction	**−7.4 mmHg**	**−8.0 mmHg**	**−7.1 mmHg**
Baseline BP Control Rate	14.4%	10.5%	16.5%
Post-Program BP Control	14.9%	15.9%	14.3%

Table 5. HHA-BPSM program clinical outcomes, combined 21-month evaluation (September 2023–May 2025). Highlighted rows indicate primary clinical outcome measures. Source: Nevada DPBH / Access to Healthcare Network. Heart Healthy Ambassador Blood Pressure Self-Monitoring Program Evaluation, Years 1–2, 2025.

> *Key Finding: 8.4/7.4 mmHg Mean Blood Pressure Reduction*
>
> The program achieved a mean blood pressure reduction of 8.4 mmHg systolic / 7.4 mmHg diastolic across 147 participants over 21 months a clinically significant result consistent across both program years (Year 1: 10.0/8.0 mmHg; Year 2: 7.5/7.1 mmHg). Year 1 to Year 2 results stayed within 2.5 mmHg despite a 78% increase in enrollment, demonstrating that program quality was maintained during rapid scaling.

Clinical and Public Health Significance

A blood pressure reduction of 8.4/7.4 mmHg is more than a number on the chart. Based on published cardiovascular risk models and the AHA guidelines, reductions of this magnitude translate to the following estimated population-level benefits for program participants:

20–25%	15–20%	25–30%
Reduction in Stroke Risk	Reduction in Major Cardiovasc. Events	Reduction in Heart Failure Risk

Figure 6. Estimated clinical risk reduction associated with HHA-BPSM mean blood pressure reduction of 8.4/7.4 mmHg. Based on cardiovascular risk modeling. Sources: AHA 2024 Primary Prevention of Stroke Guideline; Tucker KL, et al. HBPM meta-analysis.[19]

These are not hypothetical benefits. They represent the expected outcomes for real Nevadans who completed the program, people who are less likely to have a stroke, heart attack, or heart failure than they would have been otherwise. At 147 participants over 21 months, the program is already generating measurable public health value. At scale, the impact would be proportionally greater.

Who the Program Serves

The HHA-BPSM program reached populations facing documented barriers to blood pressure management, including language barriers, limited access to primary care, and lower rates of health insurance coverage. Blood pressure reductions were consistent and clinically meaningful across all participants served

Population	% of Program	SBP Reduction	DBP Reduction	Note
Program Participants	93%	−8.3 mmHg	−7.9 mmHg	*Primary population served; The medically underserved*

Female	60%	−8.3 mmHg	−8.3 mmHg	*Consistent outcomes across both sexes*
Male	40%	−8.5 mmHg	−5.9 mmHg	

Table 6. HHA-BPSM outcomes by population subgroup, combined Years 1–2, 2024–2025. SBP = systolic blood pressure; DBP = diastolic blood pressure. Source: Nevada DPBH / Access to Healthcare Network HHA-BPSM Program Evaluation.

The program's reach into medically underserved communities directly addresses one of the most documented gaps in cardiovascular disease prevention. Many Nevadans face higher barriers to blood pressure management, including language barriers, medication affordability, limited access to primary care, and lower rates of health insurance coverage. A CHW model operating in the language and community context of those it serves achieves what a referral slip to a clinic may not.

Scalability and Replication

The HHA-BPSM program's growth from 3 cohorts and 58 participants in Year 1 to 10 cohorts and 103 participants in Year 2 a 78% enrollment increase demonstrates that the model is scalable. Completion rates held steady at approximately 75% through the expansion, and clinical outcomes remained consistent. These are the hallmarks of a mature, replicable program.

The CHW model used by Access to Healthcare Network is not unique to Nevada. It mirrors approaches that have been evaluated and replicated nationally. The HHA-BPSM program provides a tested local infrastructure that could be expanded to additional counties, and additional populations.

> ### *What the HHA-BPSM Program Indicates*
>
> Nevada already has a working model for community-based stroke prevention, and it is producing real results. The HHA-BPSM program demonstrates that blood pressure can be meaningfully reduced in the populations most at risk, using a CHW approach that is culturally appropriate, scalable, and cost-effective. Expanding this model is one of the clearest opportunities in this report.

Recommendations

Statutory Authority

Nevada Revised Statutes 439.5291 through 439.5297, inclusive, enacted by the 78th Nevada Legislature (2015), require DPBH to prepare an annual Stroke Registry Data Summary and to use the data analysis to identify potential solutions for the treatment of stroke and to make recommendations for legislation designed to improve the quality of care provided to Nevadans. This section fulfills the mandate for the 2025 reporting period.

Recommendations in this report were prioritized using six criteria: magnitude of population health impact, strength of supporting evidence, time to measurable outcome, implementation feasibility, disparity reduction, and urgency of the underlying trend. **Highest Priority** recommendations address documented health disparities or rapidly worsening trends where immediate action is warranted, even when full population-level outcomes accrue over time. **High Priority** recommendations are supported by strong evidence and near- to intermediate-term implementation feasibility but do not exclusively target the most affected populations. **System Reform** recommendations require structural, statutory, or systems-level change with longer implementation horizons and are foundational to sustained progress.

#	Recommendation	Data Foundation
1 HIGHEST PRIORITY	**Develop Stroke Prevention Programs that Focus on Black and American Indian / Alaska Native Nevadans** Seek funding for culturally tailored stroke prevention programming in communities with documented highest burden. Age-adjusted stroke rates for Black Nevadans (481.4/100K) and AI/AN Nevadans (235.5/100K, up 139% since 2020) represent urgent gaps in care.	OAA Registry 2024; BRFSS Race/Ethnicity Data 2024; Age-Adjusted Rate Trend 2020–2024
2 HIGHEST	**Support Stroke Systems of Care Infrastructure in Rural and Frontier Counties**	OAA County Data 2024 (Elko: 41 ED / 24 IP); Nearest CSC: 232 miles;

#	Recommendation	Data Foundation
PRIORITY	Prioritize strengthening the rural stroke care system in northeastern Nevada and other frontier counties. This includes support for expanded tele-stroke capacity, air transport protocols for complex stroke transfers, and exploration of regional Comprehensive Stroke Center development. Northeastern Nevada Regional Hospital's Acute Stroke Ready designation and University of Utah tele-stroke partnership are assets to build upon.	Rural stroke outcomes literature (Adeoye et al., 2014)
3 HIGH PRIORITY	**Expand and Sustain the Heart Healthy Ambassador Blood Pressure Self-Monitoring (HHA-BPSM) Program** Identify funding to expand the HHA-BPSM program statewide. The program achieved an 8.4/7.4 mmHg mean blood pressure reduction across 147 participants in 21 months, consistent with a 20–25% reduction in stroke risk, while scaling enrollment 78% with no decline in outcomes. Community health worker models represent among the highest-value prevention investments available.	HHA-BPSM Program Evaluation Y1–Y2 (DPBH / Access to Healthcare Network, 2025); AHA 2024 Primary Prevention Guideline
4 HIGH PRIORITY	**Establish a Stroke Quality Improvement Incentive for tPA Door-to-Needle Performance** Seek a mechanism, such as quality improvement grants or reporting incentives, to support Nevada hospitals in closing the tPA-45 minute gap. Statewide tPA-45 rate is 60.8%. Each 15-minute reduction in door-to-needle time demonstrably improves functional outcomes and reduces disability. GWTG-S data infrastructure already supports hospital-level tracking.	GWTG-S 2024 (tPA-45: 60.8% statewide, N=393 eligible); Saver et al. JAMA 2013

#	Recommendation	Data Foundation
5 SYSTEM REFORM	**Expand Annual Stroke Data Reporting to Include Critical Access and Rural Hospitals** Find ways to extend stroke registry participation beyond the current 16 GWTG-S certified hospitals to include Nevada's 13 critical access hospitals and 14 remaining acute care hospitals. This would capture the rural stroke care data currently invisible in statewide surveillance, including patients who receive care or are transferred from frontier counties.	GWTG-S Limitations: 16 of 43 Nevada hospitals currently reporting; rural/frontier hospital data absent from registry

Statutory Reference:
Nevada Revised Statutes 439.5291 through 439.5297, inclusive (78th Nevada Legislature, 2015). Annual Stroke Registry Report and Recommendations for Legislation.

Call for Interest-Holder and Community Partner Input

The recommendations table above reflect input from Nevada's stroke systems of care partners. The Cardiovascular Health Program (CVH) actively seeks recommendations throughout the reporting period and invites all community and health system partners to submit proposals for consideration. Please contact the CVH Program at CDPHP.wellness@health.nv.gov to submit a recommendation for inclusion.


B E F A S T
Recognize Stroke. Every Second Saves a Brain.
B
BALANCE
Sudden dizziness, loss of balance or coordination
— like the world just tilted sideways
E
EYES
Sudden blurred or double vision, or loss of sight in one or both eyes
— vision that fades or doubles without warning
F
FACE
Asymmetry, drooping, or numbness on one side of the face
— ask them to smile — does one side follow?
A
ARMS
One arm weak, numb, or unable to stay raised when asked
— raise both arms — watch for the one that drifts down
S
SPEECH
Slurred, garbled, nonsensical words — or unable to speak at all
— words scrambled, missing, or just not there
T
TIME
9-1-1
Time is tissue. Time is life.
Call 9-1-1 immediately.
Do not wait.
— 1.9 million brain cells lost every minute without treatment
911
If you see any of these signs call 911 IMMEDIATELY.
Do not drive yourself. Do not wait. Do not search online for your symptoms.
Fast action saves lives and independence.
NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH
2025 Stroke Registry Data Summary • Cardiovascular Health Program

Conclusion

Nevada's stroke data document a burden that is large, rising, and disproportionately concentrated among populations with access to care barriers. The report identifies modifiable factors across four domains: hospital quality improvement, rural stroke system infrastructure, community-based prevention, and primary care access. Each domain includes evidence-based strategies with documented effectiveness in comparable settings.

This section summarizes the five key report findings potential policy directions.

Summary of Key Findings

	Key Finding	Why It Matters
1	Nevada recorded 9,064 stroke cases in 2024, a 5-year high. Adult stroke prevalence reached 4.10%, above the national average of 3.53%. From 2020 to 2024, Nevada's prevalence rose 2.5 times faster than the national rate, widening the gap from near-zero to 0.57 percentage points.	*Nevada's stroke prevalence is rising faster than the national rate. The gap will continue to widen as our population ages.*
2	Racial and ethnic differences are marked. Black Nevadans have an age-adjusted stroke rate of 481.4 per 100,000, more than double the White rate. The American Indian/Alaska Native rate has risen 139% in four years.	*Focused interventions for the highest-burden populations are a public health priority.*
3	Hospital care quality is strong overall, but tPA delivery within 45 minutes the highest standard of care is achieved statewide only 60.8% of the time. Four in 10 eligible patients do not receive the fastest available treatment.	*Closing the tPA-45 minute gap is the single highest-impact quality improvement available. It is achievable, as demonstrated by hospitals already meeting this benchmark.*
4	Elko County's Northeastern Nevada	*Expanded CSC capacity, strengthened*

	Regional Hospital is an Acute Stroke Ready Hospital with a tele-stroke partnership providing the highest level of care possible. But complex cases must transfer to a Comprehensive Stroke Center 232+ miles away in Salt Lake City, adding 3+ hours of transport time.	*air transport protocols, and continued tele-stroke investment are needed to close the gap.*
5	Nevada's HHA-BPSM program achieved an 8.4/7.4 mmHg mean blood pressure reduction across 147 participants over 21 months, consistent with a 20–25% reduction in stroke risk, while scaling enrollment 78% and maintaining outcomes.	*A proven, scalable community-based prevention model already exists in Nevada. Expanding it is a clear prevention opportunity.*

The 80% Prevention Opportunity

Approximately 80% of strokes are preventable through management of known risk factors. Primarily high blood pressure, but also diabetes, high cholesterol, smoking, atrial fibrillation, obesity, and physical inactivity.[6,7] Nevada had 9,064 stroke cases in 2024. If 80% are preventable, that represents roughly 7,250 strokes that do not have to happen. Each avoided stroke means a person who keeps their speech, their mobility, their independence and avoids the long-term costs of disability and care.

Prevention requires accessible programs, trusted community partners, and sustained investment. The HHA-BPSM program suggests Nevada can deliver effective prevention when the right model is in place.

Reaching Every Nevadan

The differences documented in this report reflect gaps in access to preventive care, uncontrolled risk factors, delayed treatment, and structural barriers, including geographic distance to certified stroke centers, lower rates of hypertension control, and limited access to primary care, which fall disproportionately on Black, American Indian/Alaska Native, and rural Nevadans.

Looking Ahead

The 2025 Stroke Registry Data Summary reflects one year of data in a multi-year story. Several trends require ongoing monitoring: the continued rise in American Indian/Alaska

Native stroke rates, the statewide tPA-45 minute gap, and the rural stroke care challenge of isolation and access. Each of these represents both a challenge and an opportunity. With sustained data collection, focused interventions, and policy support, Nevada can reverse the trends documented here and end preventable stroke deaths.

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All references formatted in AMA (American Medical Association) style. Superscript citation numbers in the report body correspond to the numbered entries below. Program and data source citations are listed separately at the end of this section.

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Suggested Citation

- Nevada Division of Public and Behavioral Health, Chronic Disease Prevention and Health Promotion Section. *2025 Nevada Stroke Registry Data Summary*. Prepared pursuant to NRS 439.5291–439.5297. Carson City, NV: Nevada Department of Human Services; 2025.

Acronyms and Abbreviations

Acronym	Definition
ACH	Acute Care Hospital
AF / AFib	Atrial Fibrillation / Atrial Flutter
AHA	American Heart Association
AI/AN	American Indian and/or Alaskan Native
API	Asian and/or Pacific Islander
ASA	American Stroke Association
ASRH	Acute Stroke Ready Hospital
B.E.F.A.S.T.	Balance, Eyes, Face, Arm, Speech, Time — stroke recognition framework
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CAH	Critical Access Hospital
CDC	Centers for Disease Control and Prevention
CDPHP	Chronic Disease Prevention and Health Promotion
CFCW	Child, Family, and Community Wellness
CHW	Community Health Worker
COPD	Chronic Obstructive Pulmonary Disease
Coverdell	Paul Coverdell National Acute Stroke Program
CSC	Comprehensive Stroke Center

CVH	Cardiovascular Health Program
CQI	Continuous Quality Improvement
CWCD	Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease
DBP	Diastolic Blood Pressure
DHS	Nevada Department of Human Services
DM	Diabetes Mellitus
DPBH	Division of Public and Behavioral Health
DVT	Deep Vein Thrombosis
ED	Emergency Department
EDRS	Electronic Death Registry System
EMS	Emergency Medical Services
GWTG-S	Get With The Guidelines®-Stroke
HBD	Hospital Billing Data
HBPM	Home Blood Pressure Monitoring
HDL	High-Density Lipoprotein
HHA-BPSM	Heart Healthy Ambassador Blood Pressure Self-Monitoring Program
HTN	Hypertension (High Blood Pressure)
ICH	Intracerebral Hemorrhage
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IP	Inpatient (hospitalization / inpatient admission)

JC	The Joint Commission
LDL	Low-Density Lipoprotein
mmHg	Millimeters of Mercury (unit of blood pressure measurement)
NIHSS	National Institutes of Health Stroke Scale
NNRH	Northeastern Nevada Regional Hospital
NRS	Nevada Revised Statutes
NVCVHLC	Nevada Statewide Cardiovascular Health Learning Collaborative
PE	Pulmonary Embolism
SAH	Subarachnoid Hemorrhage
SBP	Systolic Blood Pressure
SES	Socioeconomic Status
TIA	Transient Ischemic Attack
tPA	Tissue Plasminogen Activator (clot-dissolving medication for ischemic stroke)
U.S.	United States
VTE	Venous Thromboembolism
WINN	Wellness Integrated Network of Nevada
WISEWOMAN	Well-Integrated Screening and Evaluation for Women Across the Nation