VIRGINIA DEPARTMENT OF HEALTH

To protect the health and promote the well-being of all people in Virginia.

Virginia Stroke Care Quality Improvement Advisory Group Meeting

Meeting Location: Sentara Martha Jefferson Hospital,
595 Martha Jefferson Drive, Charlottesville, VA 23294
(Kessler Conference Room is location on the 1st floor of the Outpatient Care Center)

April 21, 2023 | 8:30am – 9:40am

Meeting Minutes

Attendance: 20 Members attended in person

Agenda	Minutes
8:30-8:35am Welcome and Minutes Approval	Kathryn Funk (VDH) opened the meeting with introductions. Mandi (VSCC Chair) motioned to approve the minutes, and Mary (UVA Health) seconded. Minutes were approved as submitted.
8:35-9:35am Coverdell Hospital Stroke Patient Reabstraction Pilot Overview and Results Hospital Perspectives Lessons Learned VSCQI Recommendations for Future Reabstraction Processes	• Kathryn shared the goal of the meeting was to talk about the data reabstraction process as a quality improvement initiative under the Stroke legislation. • Allison Sedon (VDH) presented on the results of the reabstraction pilot project via PowerPoint. • Process overview – extract records -> randomize -> distribute survey -> collect and analyze results. The number of records for reabstraction were based on patient records submitted. Data elements collected based on CDC recommendations (CDC Paul Coverdell National Acute Stroke Program). Reabstraction survey in RedCap created by VDH – 33 hospitals, 27 hospitals responded for a total of 240 records. • Feedback: Are people looking at date they left ED to unit vs presented to the ED? If a hospital is not using GWTG, some may not use when transfer was written. Age: "At time of encounter" vs date of birth. Some data may have included both outpatient and inpatient data; *Can there be branching logic in REDCap to view only inpatient which could improve matching? In Galax, some TIA patients are "ED holds" patients seen by the hospitalist virtually, could cause mismatch. *It would be helpful to have a data dictionary. Could have a sub-definition tailored to each hospital. Can include an instruction sheet or guide with the REDCap survey. NIH Stroke Scale: some hospitals document differently, some don't have doctors do it. Some hospitals

	do "first" documented NIH is the one to use, some use a hierarchy of expertise. ICD-10: Billing can take a while to update coding. • Hospital Perspectives: RECAp was easy to use. Angella (Sentara) recommends *to hospitals to keep a patient list with an identifier directory to help. UVA uses MRN + admission date. Lessons learned: two places (telestroke) can be documented in GWT, but if telestroke layer is not enabled then it could be mismatched due to no date there for IRR. Branching logic would help. Surprised Coverdell did not include co-morbidities. *VDH will inform CDC. UVA: Many charts were before the stroke coordinator was hired. Do hospitals all have an IRR process? **Recommend more time, specific guidance, aligned with GWTG definitions. INOVA Fairfax: did not receive their feedback report. VDH will include a read receipt when submitting. • VDH Question to group: How frequently should this reabstraction process be done? Group answer: Twice per year and maybe quarterly down the road.
9:35-9:40am Public Comment	No Public Comment
9:40am Adjourn	Meeting Adjourned at 9:40am