Virginia Stroke Care Quality Improvement Advisory Group Meeting

Meeting Location: Maryview Medical Center, 3636 High Street, Portsmouth, VA
Conference Room B, 2nd Floor
July 19, 2024 | 8:30am – 9:40am

Meeting Minutes

Attendance: Patrick Wiggins, Allie Lundberg, Sophea Booker, Sue Fibish, David Long, Heather Jarvis, Chad Aldridge, Wendy Bunting, Susan Halpin, Ronda Reagan, Darrel Wellingham, Beth Hundt, Mary Jobson-Oliver, Valerie Vox, Alec Thompson, Dan Solomonsky, John Gaughen. Angel Medina-Bravo.

Time Start/End	Agenda	Minutes
Start – 8:30am End – 8:45am	**Welcome and Minutes Approval**	- David Long motioned to accept the minutes, Wendy Bunting seconded. All were in favor, none opposed. - VDH communicated that future Meetings will be held in Richmond. -VDH said that the advisory group will undergo changes to be more task oriented based on the requirements of the Code, with a big focus on the stroke registry and alignment with the CDC Coverdell grant.
Start – 8:45am End – 8:55am	**VDH Stroke Registry Updates**	-David Long requested connections to EMS data in the new stroke registry. VDH responded that the registry will have EMS, hospital and acute care data. -Stacie Stevens: A long time ago, "Comments" were shared in GWTG, we want to avoid that this time. Requesting clear indicators of what data the VDH would be collecting. What layers requested, such as Coverdell layer only. -David Long: What is the benefit of the new registry? - VDH response: free to all hospitals to provide data and utilize data patient centered, more robust.
Start – 8:55am End – 9:40am	**Virginia Re-abstraction Data Elements Activity**	VDH presented the 2024 re-asbtraction results. VDH asks the advisory group – where does the principal diagnosis come from? - Rhonda Reagan: Some are complex patients with multiple diagnoses.

		- Stacie Stevens: VCU uses billing coding, we appeal the diagnosis with screenshots. This impacts documenting measures for stroke. - Mary Jobson-Oliver: Is there any way to meet with coders to educate them? Can templates be standardized? - Chad Aldridge: suggestions for VRS and CDC Coverdell to include primary, secondary, tertiary diagnosis for stroke, regardless of what GWTG does. Potential requirement from AHA is that they make every element of NIH stroke scale to be reported. Task force can recommend if we want this or not. - Stacie: I do like the hierarchy at AHA GWTG. David Long: Having NIH (6 or greater) could justify EMS hospital bypass. - Chad Aldridge: I do not think this is validated yet. Could we measure pre-hospital arrival and see improvement over time? - VDH: Could this be looked at mobile stroke unit elements to see NIH pre-hospital / post-hospital? - Mary Jobson-Oliver: iTreat at UVA measures this, but we only have a few cases. - Chad Aldridge: Teleneurology may be more widely used in Central VA because of this reason. VDH: What is the definition of the initial evaluation? - John Gaughen: It is a hub and spoke model. Could be coding out patients who had a seizure. - Wendy Bunting: EPIC – episode of care is beginning to end, sounds like the Coverdell definition of initial evaluation may be limited. - Ronda Reagan: Initial evaluation is the key difference. Example, someone could be in the hospital for 3 days and then stroke occurs, in this example brain imaging, did not occur at initial evaluation. - VDH: Could look into yes/no to drill down to see if they are a transfer hospital or receiving hospital. - Suggestion for future meeting to have a coder come and present. - Elizabeth Hundt: Coding goes by discharging physician. - John Gaughen: Could be hemorrhagic transformation.

Start – 9:40am End – 9:43am	**Public Comment**	There were no comments from the public.
End – 9:43am	**Adjourn**	Meeting adjourned at 9:43am.