Questions from American Heart Association Southeast Professional Forum
Maintaining Stroke Systems of Care During This Time of Crisis
28 April 2020

1. **For "Active bacterial or viral infection at admission or during hospitalization" there is no option for shingles or other viral infections that are non-respiratory or bacterial, aside from those listed. Will that be updated with an "Other" option?**

   J Walchok (AHA): Yes, we are looking at enhancing the question with more options. However, for this release the purpose is to capture all COVID-19 positive patients that also had strokes at your facility.

2. **GWTG is creating a separate registry, COVID CVD, while adding abstraction questions to the Stroke module. The added questions are only to document if IA and TPA treatment was delayed. We are all now in the discovery phase of the effects of COVID. I think what is being done to CVD needs to be done with stroke. Since many information is already built in, I recommend to add key questions that would identify the effect of COVID on stroke too.**

   J Walchok (AHA): The COVID-19 CVD Registry includes data collection of stroke incident and treatment. Unlike GWTG Stroke, the COVID CVD registry includes all diagnosed COVID patients and then collects any and all cardiovascular (including stroke) episodes, treatments, and medications.

3. **Any innovative ideas for caregiver support? With social distancing restrictions, there are a number of resources that aren't available for caregivers and I am concerned about lack of respite and potential increased caregiver fatigue.**

   Dr. Romano (FL): This is a challenge and I believe we can and should do more. As relatives not allowed in hospital, the teams communicate by video (when possible) or by telephone with relatives and caretakers to update them on the situation. The discharge team & educators also connect with them prior to discharge. We attempt to do virtual follow up visits on all discharged patients. I think the discharge education process should also include assistance downloading Zoom or other platforms that will allow virtual support groups. We have not yet implemented them. I worry about poor transitions of care in the COVID-19 era as it will challenging to follow up with therapy, pending diagnostics, appointments, etc. This should be actively monitored.

   Dr. Nahab (GA): Some stroke support groups have or are in process of continuing meetings via Zoom. Respite care is a challenge but I am aware of local churches who are attempting to (cautiously) assist and may be a local resource.

   Dr. Martin-Schild (LA): While in the hospital, use of Zoom Business accounts allows a HIPAA compliant mechanism for family interactions with patients and the care team. Respite care availability is a significant concern.

   K Espaillat (TN): We have been speaking with caregivers by phone mainly, zoom when able- but that is rare. We don't often see families use respite, but instead switch family members which has continued currently.

   J Luciano (AHA): See attached Caregiver Resource from the AHA.

4. **Our EMS liaison has asked if we should be treating stroke patients as suspected COVID patients secondary to it being a possible thrombolytic event similar to cardiac patients?**

   Dr. Romano (FL): We also approach every stroke as a PUI and test all strokes. Our EMS partners have added PPE to their protocols.

   Dr. Nahab (GA): We are treating every acute stroke patient as a potential COVID patient until proven otherwise. EMS approaches will depend on their local availability of PPE and our EMS agency for interhospital transfers has modified their decontamination policies after each patient as a result of COVID-19.

   Dr. Martin-Schild (LA): I'm not certain whether medics are universally using PPE for all patients, presumed COVID until proven otherwise. In the ED, one team member is using full PPE while others are more distant and communicate through the primary team member.

   K Espaillat (TN): We screen all patients/family members on scene for illness or contact with anyone sick. They all get a surgical mask. All team members wear surgical masks and gloves, enhanced PPE is only for folks with respiratory symptoms or suspected covid.

5. **Speaking of younger people having Stroke, has there been any confirmation about the patient's blood thickening and clotting, which could cause complications of the younger generation who might already have existing health problems? Mount Sinai nephrologist noticed dialysis patients catheters are getting plugged with clots.**

   Dr. Romano (FL): Our intensivists have noticed increased line (including dialysis catheters) clotting, some digital ischemia, etc, and have on occasion intensified monitoring and prophylaxis. I have not seen increased young stroke + covid cases so far.

   Dr. Nahab (GA): We have seen uniquely high rates of DVT, PE and CRRT clots in the COVID19 patient population and have found in preliminary analyses that early d-dimer levels in hospitalized patients can predict those patients more likely to have these events. We are actively studying other biomarkers that can be helpful and I've posted a link below for our current Emory COVID VTE guidelines:

   https://www.emoryhealthcare.org/ui/pdfs/covid/medical-professionals/COVID%20Emory%20VTE%20Guidelines%2021Apr2020.pdf

   Our numbers of COVID19 stroke cases are few at this time and so difficult to determine how significant COVID19 is as a cause of stroke.

   Dr. Martin-Schild (LA): The majority of COVID patient have elevated dDimer and likely are prothrombotic, probably through acute phase reactants. Intensivists are treating some with heparinization.

   K Espaillat (TN): We have seen the elevated dDimer, but the young patients have no known health problems.

6. **What was the volume of stroke cases in GWTG this March and last March?**

   J Luciano: So far there are > 25,000 records in for March 2020, we anticipate that there will be many more entered. Last year there were > 59,000.