

COVID-19 TASK FORCE

RNS COVID-19 Virtual Town Hall Executive Summary

April 16, 2020 / 6:30-7:30 pm EST

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Summary: With the growing need to get key questions and answers out to the rheumatology healthcare provider constituency, the Rheumatology Nurses Society (RNS) formed a COVID-19 Task Force to best address these questions and concerns on behalf of both their peers and the patients they serve during this pandemic. This week on Thursday, April 16, 2020 from 6:30 PM - 7:30 PM EST, the RNS COVID-19 Task Force interviewed guest panelist Eileen Lydon, MA, RN, ANP-BC of NYU Langone Orthopedic Hospital to discuss the current state of New York City and to address some of the pressing questions and topics submitted during the week from our viewers surrounding COVID-19. The following questions were raised: the recycling of personal protection equipment (PPE), rheumatic COVID-19 patients, update on studies, protocols in New York City surrounding treatment of patients, telemedicine including taking vitals, nursing and advanced practice provider furloughs.

1. Eileen, do you want to tell us a little bit about what's been happening in New York City?

Eileen Lydon: It's been a crazy month to say the least. I just can't believe that it's [been] a little over a month ago that we all started to hear about this [and] going to meetings at work with infectious disease doctors, telling us about how contagious this is [and] how many unanswered questions [there were]. We don't know if this is a seasonal thing, we don't know if it's going to come back stronger next year. Then it's getting out into the public and we're talking to our patients in the clinics and they're asking all these questions [that] we really don't have any guidelines of what to tell them, [like] what do we do with [the] medications? We're sort of just all brainstorming together about the best approach for this. Then the next thing we're having all these weekly meetings at work about how overloaded the hospitals are

going to be and what are we going to do? They're just basically telling us it's going to be all hands-on deck. We are all going to be called onto the floor in one way or another, just be prepared for that. What happened was, I worked at an NYU hospital [in] the orthopedic hospital, which is separate and is about 10-15 blocks away [from the main campus]. Since they don't have any orthopedic procedures going on right now, they decided to make that hospital an overflow of the patients at the main campus, [from] the Long Island hospital Winthrop, which is also NYU [and] a hospital in Brooklyn as well. I've been doing that, I [would] say, for the last 3 weeks or so. At first, it was a bit chaotic. Everybody who is working on those floors has never done that before [because] they're coming from outpatient places. Physician assistants (PA's) that usually work in the operating room (OR) are coming up [along with] surgical nurse practitioners. The orthopedic surgeons have shown up on the floor. We basically just all got in there together to take care of medical patients with COVID[-19]. That was kind of a nerve-wracking experience to say the least. We [have] pull[ed] it together [and] it is a bit more organized [now]. We have a nurse practitioner who helps take the admissions, another one that helps with discharges, and we split up into teams. I have my own panel of patients [and] I work with the hospitalist as well, [who is] actually a geriatric hospitalist that also wasn't normally working in that environment. We just all do our best, we all communicate. And even though a lot of us don't know this system, everybody is willing to help, and everybody is just trying their best. I feel we're still really busy. I know that the numbers are going down, the admissions are going down, and hopefully [we] will start to see that soon. But the reality is, we have a [mostly surgical] hospital that is fairly full right now that is normally not. So, I guess it's going to be a little bit more time. I'm on till the end of May right now, so for two full months I'm on there. I guess we will see after that if the numbers start to decline.

2. What is happening with your rheumatology patients while you are working on COVID-19 patients?

Eileen Lydon: They're pretty much switched over to telemedicine for the most part. Mondays and Tuesdays, I am in the hospital. Wednesdays and Thursdays I have them booked for the telehealth visits. We do have one point-person that will be available at the clinic should we need a patient to actually come in. Sometimes we have to examine them. But it's been working out fairly well, for me anyway, because most of [my] patients are follow-ups. I haven't had any new [patients], so I know them pretty well. Just trying to get them plugged in [and] getting them labs as an outpatient. The actual face to face is so nice [on televisits]. Sometimes we can't, we just do the phone call. But that face to face really does, I think, make us both feel like we're connecting on that level. The patients very much appreciate it. You feel like at least you're keeping up. It's just so interesting because we haven't done this before, and it [happened] overnight... "okay, we have to watch these learning videos on how to do telemedicine" and again, it's nerve-wracking because we [had] never [done] it before.

But it's actually working out quite well. I think it will be interesting what the future holds with that.

3. *We hear so much in the news about you not having enough personal protective equipment (PPE). How is that going, are you getting what you need?*

Eileen Lydon: At NYU, they are giving us everything that we need but we obviously have to conserve it, we can't go crazy. From day one, whether or not we technically needed the N95... we were told you could wear surgical masks if you weren't working in, let's say the ICU scenarios. If you weren't involved in suctioning or [invasive] patient procedures, maybe you wouldn't need it. But from day one, they gave [them] to us; the N95 and we have our face shields and gowns, the caps for our hair. There were even people on the floor that were just there to help us with our PPE, sort of like "hey, you're contaminating this" and just remind us. You're nervous about taking care of patients because you're not sure how they're presenting and it's our knee jerk reaction to run into the room when somebody is short of breath. Then all of the sudden, you have to stop and take those few minutes and just say "Okay, I got to protect myself first". It takes a couple of minutes to get going, then you come out [of a patient room] we have bleach wipes, and we have stethoscopes that we are bleaching down, and our face shields in between patients. You start getting the rhythm of it, but it does take time to get it going. Definitely, there was always enough. There was always enough outside of every room, so I never felt unsafe that way.

4. *Is your hospital reusing PPEs by sterilizing the N 95 masks or are they just throwing them away?*

Eileen Lydon: They are reusing them, I mean not reusing, but we have to put them in a separate bin. Every week they give us a new one and then we give our old one back. [Is anyone] doing that as well?

Vickie Sayles: We are, we just started.

5. *Have you seen any of your rheumatology patients present with COVID-19?*

Eileen Lydon: I have. I talk to them on the phone [and] a couple of them have turned. One of them was admitted to the hospital and she was just discharged today. There was one that

required a few more days of being admitted. She was an RA patient of mine on Enbrel and she just stopped [taking] it a few weeks before because she was just nervous about everything. She stayed in the hospital for five days. A lot of the patients can't [be] transitioned over to us. They're stabilizing, but they still have some oxygen requirements and we can't quite get them off the nasal cannula. Their lungs sound really crappy. That was her. She was on and off the oxygen but eventually she got discharged. Her husband [was] actually at a different hospital [at the same time]. He also had [COVID-19] and was intubated in the ICU. I'm not sure what the actual outcome was out of that but that's been my experience. I'd say all in all, I probably had three patients so far that I know had COVID[-19].

6. *Is it beneficial to keep these patients in the prone position?*

Eileen Lydon: Because I'm not working in the ICU environment, I'm not seeing any of that [and] that's the first time I actually have heard of it as well. I looked it up and [started] reading a little bit. I guess it seems that patients that are vented in the prone position seemed to do better but that's really all I know about it. I never heard of it before this either.

Cathy Patty-Resk: So, it's pretty much just the vented patients it's not just anybody

Eileen Lydon: I think so.

Carrie Beach: I was reading in a nursing post or a health care provider post earlier about them doing CPR that way. Work patients in the prone position, it's interesting.

7. *Eileen, can you update us on current studies surrounding COVID-19?*

Eileen Lydon: One thing I'll say is that when the patients that I'm seeing come over to us, the vast majority of them coming into the hospital require some oxygenation [but] this is not a study. They're really putting them all on hydroxychloroquine and azithromycin for a five day course. Since then, what I'm learning from all the email strings I'm on, what's being approved at NYU, there is one [medication]. It's called PrEP, and it's actually a pre-exposure prophylaxis. This is for NYU health care workers at work before they go into that setting. It's given to them as the prophylaxis of the hydroxychloroquine, just to see if that helps prevent them developing COVID[-19]. Then there's another one, [which] I think this is the Belinda Gates study. The hydroxychloroquine versus placebo [study] which is vitamin C, and this is the post COVID[-19] prophylaxis exposure. So, if you knew of somebody that had COVID[-19] and you were exposed to them. [There is] another one actually using Colchicine versus placebo, and these are for our patients who have COVID[-19] [that are] not sick enough to

come into the hospital. We have all those going on [for] outpatient [studies]. Then inpatient, when I was first there a few weeks ago, some patients were being put on the Kaletra, the HIV combination. I'm not seeing it as much anymore and that's not a study but that was just an antiviral option. The antiviral that is under study is the Gilead drug Remdesivir. So, again, I'm not seeing that where I'm at but it's happening at the main campus where all the clinical trials are. I'm hearing [that] it depends sort of [on] what floor you're on and the trials that you're exposed to. Those are the antivirals. Then finally for the cytokine storm, the IL6's and tocilizumab, were familiar from what I understand. That's off label, it's not a clinical trial, but I know some patients are getting that. We have sarilumab at one campus that is undergoing clinical trials. They just started another IL6 called clazakizumab, which I think just started about a week or two ago. That's a drug that's used to help protect against kidney transplant failure, and now that they started using that in trials. I'm sure there's more like [it] on the way. Those are the main ones that I know of.

8. Have you been tested and if so, how long did it take to get your result?

Eileen Lydon: I was. I think maybe 3 weeks ago. NYU told us that we could be tested even if we were not symptomatic. [It is] just reassuring to know that [it is] available to us. Those that were being exposed to COVID[-19] patients were the ones that came out. [I received results] within 24 hours, actually I did go back that night. Testing is interesting though. I saw a couple of patients that tested negative [at] first [but] because it [was] high suspicion, we tested them again and [more have] been coming back positive. From what I understand, maybe it's the sensitivities, about 70% of that, and they're doing the nasal swabs but sometimes it's the lung secretions deep in the lung [and] we're not getting all of that. I found that really interesting. Those two patients I saw were quite ill and they had tested negative first.

Linda Grinnell-Merrick: We're not testing. Our testing is still rather limited here even though we're in New York state. I wish we were testing a lot more but I think we're seeing a lot more negatives than we certainly see positives, and then you do worry or wonder. Are they false negatives and they really do just have [it]?

9. Is anyone performing the rapid testing at your facilities yet?

Eileen Lydon: Is that the 45 minute one?

Vickie Sayles: 45 minutes to two hours.

Eileen Lydon: I've heard of that, but I'm not sure.

Vickie Sayles: We just started that this week. We have several different ones that we're trying out.

Eileen Lydon: The other thing with the patients that I'm seeing in the hospital too, is they're positive but then they're getting better and we're trying to send them out to nursing homes or rehabs and they want two negative COVID[-19] tests. The patients that are going home are asking these questions, "while you're sending me home and I'm still positive" and "I have to go home to my wife and my kids. What is this all about?" and we really don't have the answer. If they're positive, they could still be shedding and still be contagious. It's hard because we don't have the answers and you understand their anxiety.

10. Has anyone heard about the possibility of reinfection?

Eileen Lydon: I've also heard of that as well. You want to think that you're building up immunity and you're not right back again [with COVID-19]. It's really scary.

Cathy Patty-Resk: It's bad enough to think you might get this once but just think about getting it twice, it's like you got to be a cat and have 9 lives with this thing around.

Eileen Lydon: I heard somebody talking about the antibody test and it will be amazing. Some people, they think, don't actually make antibodies where there are certain people that make them initially. Then they are not there anymore a few weeks later. [There are] so many unknowns. With our other scenarios, it's not the case, we build up antibodies.

11. What is the morale of staff that you're working with right now?

Eileen Lydon: Well, the people I'm working with are fabulous. Everyone is just popping in, just helping each other out. I'm the one who's asking a million questions all the time. One of the hospitalists we work with, his wife has tapped into all the food venues in New York City that are donating free food. We're almost getting used to that. He just texts us at 12:00 and he says "we have free lunch again". It's things like that. Literally you really [are] not sitting down, it's hard for me just to walk upstairs to the cafeteria. You're also just going on and off the PPE and you're just going [non-stop]; so just those 15-20 minutes we just kind of all sit together and just grab a bite and we are just so grateful to kind of forget about it for a few minutes. I think the morale has been fantastic for people who this is not what they normally do at all every single day and everybody was pretty darn scared. It's been amazing, everyone wants to do what they can to help.

12. *What are you doing about your standard protocols when it comes to charting and vitals? Have you had to cut back on things just to get through the day?*

Eileen Lydon: I think I know you what you're getting at, but I'd say in general, I'm doing everything like I normally would. I think you do kind of have that mentality of prioritizing and I think people are understanding that things maybe aren't going to be as perfect with policies and procedures. In general, they haven't been even though it's super-duper busy because we have a lot of people out [there], [all] hands on deck. It hasn't been really that bad. I feel as though they're getting good care and we're still following protocols.

13. *Are you helping patients when it comes to being isolated from family members? For instance, there have been news articles about hospitals in New York City providing iPads so patients can communicate with their families?*

Eileen Lydon: I know there's a lot of that. It's really so upsetting. I, most every day, will be on the phone with families at least a few times a day to give them updates. There's a lot of that. They're going to FaceTime phones or the iPads as well, [it's] very isolating, especially the whole husband and wife [separation] I see. I saw that a few times, where the husband is in a different hospital sick and the wife is somewhere else. They're really separated, it's really hard.

14. *Are there support systems in place for you for your mental health?*

Eileen Lydon: There are a lot of support emails all the time about mental health services for ourselves. There have been a few deaths but I haven't been dealing with that personally with my patients as of yet. We have some DNR patients and we may start getting more of them now. I don't know if it can be "hospice" because I don't know if we are able to do that, we are not credentialed to do that, but there has been some talk [of] bringing more of those types of patients and having those conversations. Working with the geriatric hospital as we are, there are nurse practitioners up in the main campus that we get on the phone with that you do more of those kinds of conversations with patients. I guess the answer is that the right people are in contact with these people that do that more day in and day out. You don't get emails about [how] we may have to go down that road and we may have to learn more how to actually get Hospice care and all that. On Mondays I just go through all my

emails and try to update myself and all the new policies or what I need to know to get through. Just like what can happen with any viral infection; or are they getting re-infected? So, hopefully not that, but the jury's still out.

15. What does your typical day look like outside of your work day?

Eileen Lydon: You mean when I'm not working? I am walking with my mask on. I have to, just this whole being inside all the time, it just makes you crazy. I'm sure you guys can totally relate with that and it's just stressful. Getting out in the sunshine and just having other distractions, going walking in the park, looking at a dog or whatever it is. I have a friend who lives in my building and we walk, obviously six feet apart, but we just walk and chat. I think we did a couple of half marathons, like 13 miles a couple of times over the last couple of weeks. We just kept hiking all around Manhattan. Talking to friends and I'm sure you guys are doing it like this, Zoom, and you get everybody on, people you haven't talked to in forever. So, there's been a lot of nice things. I'm sure you guys can relate with that as well, connecting, simply having time. There is a silver lining.

16. Have you changed the way that you're doing vitals?

Eileen Lydon: You mean with telemedicine? Because we're not [taking vitals] with the televisits.

Carrie Beach: In our office, we're not. I believe infusion is still doing blood pressures but we have been asked not to have any contact. So, no blood pressure, no pulse. I actually had my first televisit with my family doctor and they want you to type in your vitals. I was able to guess my height and lie about my weight and then it was like, "do you have a blood pressure cuff?". I wasn't prepared, but you could enter all of that on your own. Infusion is still doing everything, just the patients that we're seeing for injections or whatever, we were holding up on blood pressures right now.

Vickie Sayles: We're still doing all of our vitals for all of our patients. Anybody that actually comes in the office and then the infusion room is still doing all of theirs.

17. How about temperatures? What are you doing for those?

Vickie Sayles: Today was the first day I walked in to the Cleveland Clinic and they had thermal scans, I was surprised. They used to have people standing at [the] entrance taking

your temperature but today, they had thermal scans so you just keep walking. It's kind of neat.

Linda Grinnell-Merrick: How [does] that work? [Do] they watch something or [is it] just like a gun that shoots?

Vickie Sayles: It's not even that, it almost looks like security cameras as you're walking through. They are placed in different spots and as you're walking through I guess it takes your temperature. I would have to look it up, I was kind of surprised. This morning it was freezing cold here, so I'm like how did that get my temperature after coming in from outside?

Carrie Beach: I wondered about that with ours, because of course, ours is right as you come into the building where we're taking temps. I wonder about the accuracy as soon as they walk in the door and we scan.

Vickie Sayles: A lot of times they have me lift up my sleeve or something if I was just outside. They'll take it on my arm or they'll take the thermal scans. There was somebody sitting with a computer, so I don't know if that person saw your temperature. I'm going to have to look into that a little more. It's kind of interesting.

Linda Grinnell-Merrick: I donated blood last week and they were still doing oral temps. I think sometimes they're limited on supplies also, but I just thought that was interesting. I had to take my mask off so they could take my temperature so that was different, but still important to donate blood because the blood supply is so low right now.

18. Are you concerned about patients who get infusions not being able to get appointments soon, due to space limitations?

Carrie Beach: I know in our [infusion] office right now, and I know I've talked about this before, I think we have six chairs now that we've spaced out into a different part of the building and with the lack of patients that we're seeing right now we could still expand on that more. We're not having any issues with patients being able to get in and get their infusions.

Vickie Sayles: I'm more worried, not right now we're still pretty full, but my worry is [for] the people that are canceling now [that] want to wait a couple of months before coming in because they were afraid to come in. I'm worried about what's going to happen in June and July when all of these patients need to get in for their infusions. I've been proactively scheduling all of our IV/IGs and rituximab that I can find into June/July, actually I'm scheduling them to the end of the year, hoping that at least we can get as many in as

possible that always come monthly or come every six months or every four months. I see it as being a big problem starting in probably June or July.

19. Have you seen any furloughs for nurses yet?

Cathy Patty-Resk: Our hospital is furloughing about 500 people this week and there's still more to come tomorrow and we're just kind of wondering. We have a hospital up here, not one of our system hospitals but a different system, and they have a hospital that's completely empty. They furloughed every single worker out of that hospital. There are no patients in them. I think what's happening here is we're preparing for the 2nd wave. They're not relocating them, they're furloughing them until like mid-July. I'm really shocked that the pediatric nurses and nurse practitioners haven't been reassigned like you guys, Eileen. The adult hospitals are just dying. They're just so overworked and because you're at capacity, they are not so much overcapacity. We were in the news yesterday because our governor, she's really doing a great job and they're just really making it tough, but I have a feeling she's going to be forced to lift the stay home stay safe order at the end of the month and I think the hospitals are starting to get ready for the 2nd wave because they know it's coming.

Carrie Beach: That's pretty much what they're doing here in Ohio too. We're very blessed, I think we're doing really well as far as the amount of patients here, but the governor today said that May 1st he was going to start [opening]. Not everything up, everything is going to be in a phase. I think we've also had a lot of protesters, so I think [they are] telling them kind of what they want to hear, that they're going to lessen some of the restrictions starting May 1st.

20. What is the current environment with restrictions in your area and how is it affecting your everyday life?

Cathy Patty-Resk: The whole working from home thing has been a challenge, but the folks that have the kids at home that are doing the home schooling... I don't know how you guys are doing that.

Carrie Beach: It's very tough, it's not fun. I'm not working from home, my husband is, so he's in the office actually taking part. He's very busy and so it's very frustrating. That's my full-time job when I'm home and thank goodness I'm only working 2 days in the office now so I can at least be home those other three days. I have to literally walk my third grader through every single assignment and sit there while she's doing it. They're very used to iPads and phones but laptops are a little different.

Eileen Lydon: It is sad to think about the future. They're talking about [here] in New York, maybe closing the beaches for this summer. Concerts you have planned for a few months from now, I know in reality it's probably going to have to be the way, but you don't want to think about that now some months ahead. It's sad.

Cathy Patty-Resk: We're used to living in the United States of America where we have all these great freedoms. [The] right to go to all these events [safely] and don't really [have to] think anything about it. It's just really rocked our world.

21. What are the highest risk patients that should still be seen by rheumatologists?

Vickie Sayles: Vasculitis.

Eileen Lydon: You mean coming in and not on a televisit?

Vickie Sayles: I think most of ours are vasculitis that are actually coming to the office.

Cathy Patty-Resk: That's pretty much what we've had coming to the office, that or today I saw someone in the office that was a new diagnosis JIA that was just started on Naperson and spondylo, so I had to see them today and I knew she needed to be looked at.

Eileen Lydon: The sicker lupus patients, right?.

22. How are your televisits going right now? Have you found any patients that are too difficult to see through televisits?

Linda Grinnell-Merrick: I sent somebody in for tomorrow. She's got bilateral knee effusions and is postpartum, starting to flare after that baby. We have someone that's in the office, so I'm sending her in tomorrow to get some of that fluid drained off and get some steroids. Hopefully get her back on some treatments. I think it depends, I think every provider has a different level of managing them or not by phone from patients, which is hard to challenge. I did a home visit, a televideo visit yesterday, and it's usually easy. Lift up your pant leg, that was really easy. This lady's looking at her hands, I honestly couldn't tell if they were swollen or not. I had her gripping, making fists and trying to figure it out. She was a new patient and it's just trying to sort through that. I'll see her in a few weeks when we're back up, hopefully in the office, because it was really hard. I think you just have to know your patients and if you don't, just make the best judgment you can.

Carrie Beach: [It's] really hard to do new patients that way. I know the physician I work with is doing them, some of our physicians are not. My physician always offers, "let's try, let's see how it goes" and she said it's hard. It's definitely more difficult because you don't know what the patient has but at least we can kind of get that relationship established and then she can order labs and appropriate testing.

Linda Grinnell-Merrick: I think it kind of helps the patient because they are talking to somebody, otherwise we're telling them we can't see them for however far out. [One] patient waited for this appointment for months, they've been waiting six months already. I put lab orders in, I told her to go when it was convenient [and] shouldn't have to rush out there. She went today, got her lab results but it was important to her that somebody still spoke to [someone]. [If] nothing else, I got a good history. You do listen to history a lot more careful when you can't do a big physical exam I think. So, you're listening to that history and picking up on other things and hopefully shortly, [I] will be able to see her in the clinic and do some more specific testing.

Eileen Lydon: We are all hoping in a couple of months' time we will get to be able to see them back in. [This is] not going to be good for the long term for certain people, for sure no.

23. *Has anyone heard of any records of drug shortages at infusion centers?*

Cathy Patty-Resk: No, our infusion centers have been doing really well with drugs. We haven't had any problems, and I haven't heard that our infusion center staff is furloughed. I would not see that happening. I don't think it could happen even if they closed our building, I think they'd have to relocate the infusion patients. I think if anything stays open in our building, that's the part that will stay open.

Carrie Beach: We've kept all of our infusion nurses full time. Everybody else [is] kind of getting cut back on hours. Luckily, we are very fortunate to be paid for those hours but definitely infusion is going.

Vickie Sayles: The infusion patients need their infusions and a lot of them, if they don't have them, they're going to end up in that high risk hospital right. I think to prevent that, we're going to have to keep them in our setting.

Cathy Patty-Resk: I think it was about a week now, and one of my infusion kids was getting Actemra for systemic onset JIA, and her medication was being given to a COVID[-19] patient, so they called the mom and cancelled her. I did have a conversation with the manufacturer and the problem is that some large hospital systems have been stockpiling that medication. I believe on our COVID[-19] website, there is a resource that if you're

having that problem with tocilizumab, there's a national person that you can get in touch with if you're having that problem. Go to our COVID-19 Resource Center and you should find some additional resources there if that is a problem for you.

Linda Grinnell-Merrick: I know many of our pharmaceutical companies have been reaching out to us and asking us if there are any issues with shortages and even bridging people because we're anticipating lots of people [are] going to lose insurance down the road. Unemployment rates are going to go up. I had, I think three at least, three emails today from different pharma representatives telling us that they will have bridge programs available. I believe AbbVie just sent one to RNS actually, that they will have bridge programs put out to help patients. They can still get their medication. Reach out I think if anybody [is] seeing any kind of shortage and not getting meds for their patients to reach out.

Cathy Patty-Resk: Definitely let us know because we're putting that up on the RNS website under the COVID[-19] tabs, so let us know if anyone is having issues anywhere.

Eileen Lydon: I agree the companies have been reaching out to me.

24. Have you changed the way you are addressing patient concerns about continuing their medications?

Linda Grinnell-Merrick: The last thing we want is for these patients to flare. In one of the questions, patients were scared and they don't want to come in, but you don't want them to flare and end up being in those emergency rooms or admitted into those hospitals. It's one of the things I talk about when they want to stop their meds, and it's like "Oh my goodness no I don't need you to flare, we don't need to give you a bunch of steroids right now" and really kind of have a nice conversation with them around those risks that they're taking if they stop their meds.

Carrie Beach: I think it's just a good education point really, I know especially with our infusion patients. All of our inpatient patients are getting calls from one of our physicians assistance 24 hours before their infusion to discuss why they really still need to be on their medication and all of the wonderful precautions that we're taking in our office to ensure that they're safe. I think that's helping them.

Eileen Lydon: I'm getting a lot of people that just haven't talked to [us] and they just stopped their medicine suddenly.

Carrie Beach: That's what scares me the most. The ones that aren't calling me.

Eileen Lydon: And I think, to their credit, I think because we coach them so much about if they have fevers or infections you need to hold it and they just sort of put that in the same bucket here.

Carrie Beach: They think they're preventing the infection.

Linda Grinnell-Merrick: I'm just explaining that your immune system is already regulated by the disease. Yes, we have this added risk, but just kind of talking them off the ledge a little bit and kind of stepping back and talking about the disease process sometimes helps them to just focus about why I am taking the medication and why I don't want to have a flare and how bad I feel, how sick I feel when I'm in a horrible flare before I was treated. It takes spending a lot of time talking to our patients.

25. How can case managers help their patients with without reaching to RA patients right now?

Carrie Beach: I think we just need to educate patients on what flaring of their disease can do and [how] that can put them [at] an increased risk for complications. I think, again, it's just trying to reassure them that they need to take their medications.

Conclusion: As the COVID-19 virtual town halls have continued, the task force introduced guests to join them in various parts of the country. The guest this week, Eileen Lydon, MA, RN, ANP-BC of NYU Langone Orthopedic Hospital is located in the heart of New York City, a hot spot during the pandemic. She covered various topics from upcoming clinical trials and research being done on behalf of COVID-19 as well as the way of life for her in New York City and how her life has changed as an advanced practice provider during this pandemic. For the pre-recorded broadcast that accompanies this report please be sure to go our website at www.rnsnurse.org/covid-19/task-force/