Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.
Pandemic. The markedly elevated rates of admission from the ED to the hospital about delays in care due to the public testing capacity, and other resources can quickly be overwhelmed without advance response at the epicenter of the crisis. Similar patterns might be observed if COVID-19 areas throughout the COVID-19 pandemic, it is important to note the two-stage the declined referrals, failure to meet program criteria was most common (32 patients, 18.8%) followed by direct referral to the ED (16 patients, 9.4%). Most referrals came from our RIC (54.7%) followed by ED (22.4%) and PCP (20.8%). The majority of patients (90.6%) were COVID-19 positive or had results pending at the time of enrollment. Of 23 (22.6%) patients experiencing high-risk symptoms at the time of evaluation, ambulatory oxygen saturation < 91% was the most common (17.4%). Overall 92.2% of patients evaluated by our MIH program were able to continue in-home isolation with the remainder referred to the ED. There were no emergent transports to the ED.

Conclusion: During the COVID-19 surge in Massachusetts, our program successfully prevented 93 ED visits among 102 patient evaluations. By reducing ED use, we were able to preserve limited hospital resources including personal protective equipment and ED beds, reduce infectious exposure to both staff and patients, and reduce associated healthcare costs. Further, we mitigated health disparities by providing care to those with limited health care access, both physical and technological. While our program was safe and effective, with no patients requiring emergent ED transport, future evaluation of a more robust set of outcome data is warranted. MIH programs for COVID-19 response can prevent ED visits by safely evaluating and managing vulnerable patients with low-cost, high-quality home-based care.

Study Objectives: Heightened immigration enforcement may induce fear in undocumented patients when coming to the emergency department (ED) for care. Limited literature examining health system policies to reduce immigrant fear exists. In this multi-site qualitative study, we sought to assess provider and system-level policies on caring for undocumented patients in three California EDs. Methods: We recruited 42 ED providers and administrators from three California EDs (in San Francisco, Oakland and Sylmar) with large immigrant populations. Participants were recruited using a trusted gatekeeper and snowball sampling. We conducted semi-structured interviews that included queries about providers’ knowledge of and suggestions for policies and practices to reduce fear and enhance trust among immigrant patients in the ED, among others. We analyzed the transcripts using constructivist grounded theory. Results: We have interviewed 41 of the 42 ED providers: 10 physicians, 11 nurses, 9 social workers, and 11 administrators. Their median years of experience was 12 years. We identified 7 themes. Two thirds of participants were aware of at least one of the two key policies that inform care for undocumented patients in the ED. Recent practice/policy changes specific to undocumented patients included increased inclusive messaging and further restriction on immigration enforcement around and inside of the hospital. However, there is variation across and within sites in knowledge, including around status and policies. Providers reported that current training around policies and best practices for supporting undocumented patients is limited; communication about existing or new policies is mainly email-based and disparate among provider types. We identified uncertainty about policies, laws, and the jurisdiction of staff across a majority of interviewees. Providers stated that they are taking an active role in building safety and trust and see their role as providing resources and support to undocumented patients.

Conclusions: This study introduces ED-level health system perspectives and recommendations for caring for undocumented patients. Providers in three California EDs, which serve large immigrant populations, report existing policies and recent policy changes that facilitate access to care for undocumented patients. But even within this “sanctuary” setting, providers identify opportunities for growth. There is a need for active, multi-disciplinary ED policy training, clear policy details including the extent of providers’ roles, protocols on the screening and documentation of status, increased patient communication about policies, rights, and resources, multi-sector collaboration to address gaps in resources for undocumented patients, and continual reassessment of our health systems to reduce fear and build safety and trust with our undocumented communities.