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Study Objectives: Mobile Integrated Health (MIH) programs combine community paramedicine and telemedicine to deliver urgent medical care in patient homes. During the COVID-19 pandemic, MIH has significant potential to mitigate concerns about COVID-19 infection from seeking urgent care in health care settings. The MIGHTy Heart ("Using Mobile Integrated Health and Telehealth to Support Transitions of Care among Heart Failure Patients") study is a comparative effectiveness pragmatic trial comparing a transitions of care coordinator to MIH. Recruitment began in January 2021, 10 months into the pandemic. Existing challenges to patient engagement in research have become more pronounced during the pandemic; studies show that pre-COVID-19, less than 50% of trials met proposed timelines for recruitment, and early evidence suggests this number has dropped during the pandemic. Here we report on the challenges and solutions for recruiting patients in emergency medicine-focused programs during the COVID-19 pandemic in the first 5 months of recruitment.

Methods: We convened a Stakeholder Engagement Board (SEB) including nurses, patients, community paramedics, and case managers. We conducted a descriptive, thematic synthesis of the SEB discussions to address the challenges. We implemented strategies for increased enrollment generated by the SEB two months into the MIGHTy Heart study and evaluated changes in the proportion of patients enrolled among those who were eligible for the study before and after implementation of these strategies.

Results: We identified 4 significant COVID-related challenges to recruitment into the MIGHTy-Heart study. COVID-19 patients excluded from inpatient recruitment: 18% of screened patients (n=287) were COVID-19 positive while inpatient, and hospital policy prevented the team from approaching them in contact isolation. Limited family presence: the hospital visitor policy restricts visiting hours to 4 hours and 1 family member. Patients are more likely to participate if the decision is made with a family member. Due to COVID-19, patients are more reticent to allow any health care providers in their homes out of concern for possibly infecting other family members with COVID-19. Mandatory mask wearing in the hospital has posed barriers to communication, especially for some of the elderly patients, who may rely on visual and auditory cues for verbal communication. From the SEB, we identified 3 strategies to support patient engagement. Virtual recruitment: after discharge, patients who were COVID-19 positive were contacted by phone or email. Patients were emailed the informed consent and study materials. Family engagement: per patient request, the research assistants would call patient families if they were not at the bedside at the time of recruitment to explain the study and answer any questions that family members might have. Study materials were left at the patient’s bedside for patients to read and share with family members in advance of deciding to enroll in the study. The proportion of eligible patients who enrolled in MIGHTy Heart increased from 28-32% before these strategies were implemented to 46-52% in the months after implementation (Figure 1).

Conclusion: The novel solutions developed by the SEB and study team increased enrollment in the MIH program. These strategies may be useful for others facing challenges to recruitment in emergency medicine-related programs during the COVID-19 pandemic.