

# Barriers to Infant Preventative Care During the COVID-19 Pandemic

Jane Henriques BS, Jessica Weisz MD, Mallory Lacy RN, Julie Krueger MD, MPH, Jennifer Jiggetts BA, Claire Boogaard MD, MPH

## Introduction

In spring of 2020, the COVID-19 pandemic disrupted all aspects of life for Americans, including their access to healthcare. To decrease community spread of COVID-19, local governments began closing nonessential services. Hospitals and medical clinics were declared essential<sup>1</sup> and encouraged in-person routine vaccinations;<sup>2</sup> however, preventive care visits in pediatric clinics declined. National preliminary data of Medicaid use from March to May 2020 showed a 44% decrease in the use of screening services compared to the same time period in 2019.<sup>3</sup> Vaccination rates for children under the age of 2 also decreased during the same period by 22% compared to 2019.<sup>3</sup> In addition to the health risks innately imposed by COVID-19 infection, the decline in preventive visits put infants at additional risk of vaccine-preventable infections, missed identification of delayed development, and decreased ability to foster family-child mental health, all of which are mainstays of preventive care.<sup>4</sup>

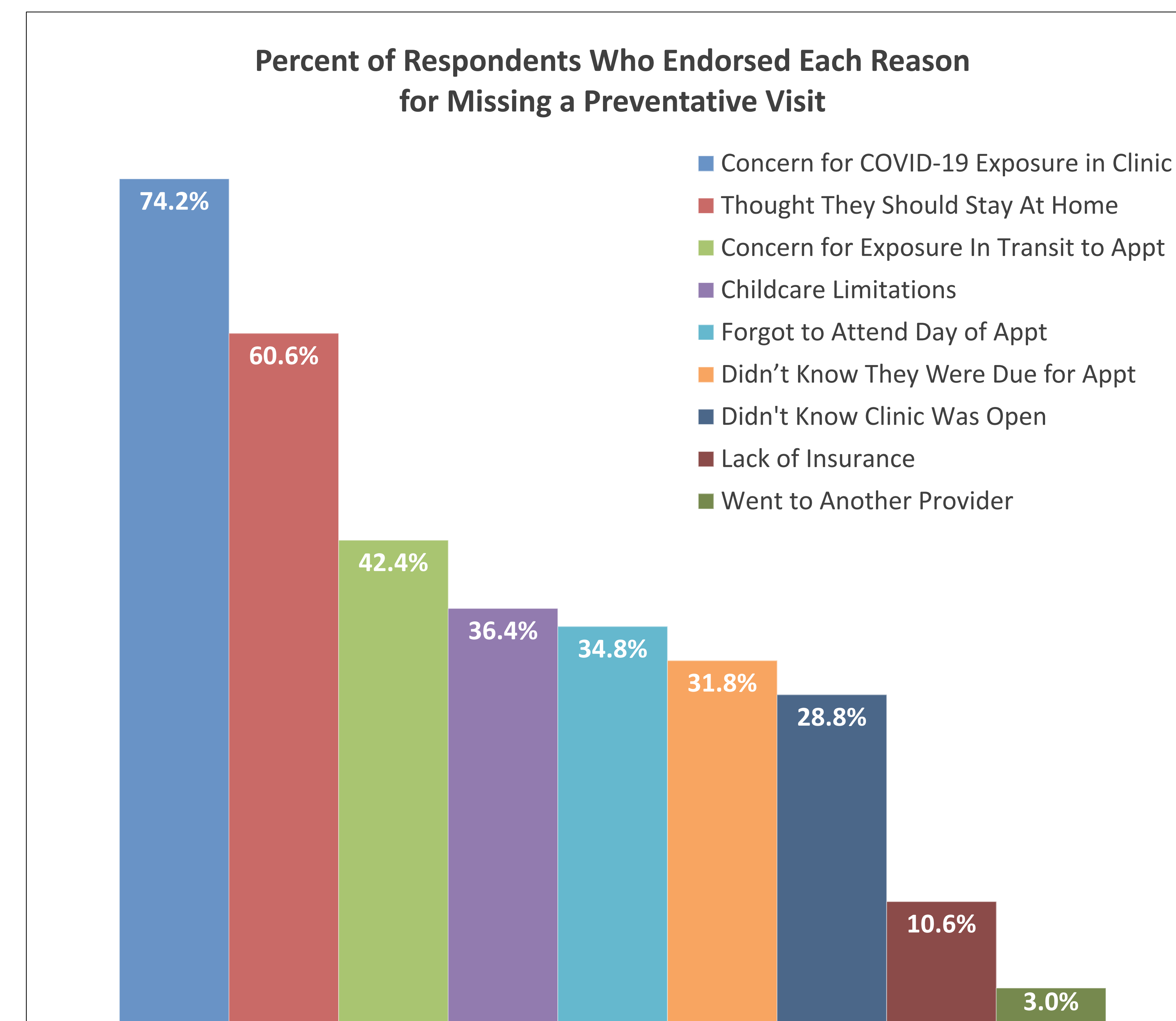
Recognizing that the increased risks of COVID-19 exposure and diagnosis are not shared equitably among populations is critical when examining use of preventive care services. At COVID-19 testing sites organized by Children's National in March and April 2020, Black/African American children were 2.3 times more likely and Hispanic/Latino children were 6.3 times more likely than non-Hispanic white children to test positive.<sup>5</sup> This increased risk is a consequence of longstanding systemic health and social inequities and needs to be considered when examining community behavior during the pandemic.<sup>6</sup>

To decrease the risks associated with delayed preventive care during the pandemic, barriers to receiving preventive care need to be assessed. Although many reasons for decreased visits can be assumed, no studies have reported parental perceived barriers to care during the pandemic. During the pandemic healthcare changes were made quickly and without understanding of parental concerns or barriers to care. This information is critical to preventing disruptions in care delivery for patients throughout this ongoing pandemic and for any future public health emergencies.

## Methods

- Retrospective EMR chart review of three academic outpatient centers in Washington, D.C. identified patients who missed a 2, 4, 6, or 12-month preventative visit by at least 1 month between March 16th, when the shut-down of nonessential services in D.C. began, and September 30, 2020.
- Respondents who verbally consented completed a telephone survey in English or Spanish. The survey included self-reporting of primary mode of transportation to the clinic, nine closed-ended questions, and an opportunity for one open-ended response.
- Respondents could endorse more than one survey response.
- Demographic information was collected via the EMR.
- No financial incentives were provided. Appointments were made by the study team when necessary and requested.

Category	Variable	Respondents (n = 66)	Eligible Nonrespondents		P value
			No Contact (n = 175)	Refusal (n = 103)	
Insurance	Public	58 (87.9%)	144 (82.3%)	86 (83.5%)	0.70
	Private	2 (3%)	10 (5.7%)	4 (3.9%)	
	Not Documented	6 (9.1%)	21 (12%)	13 (12.6%)	
Race/ethnicity* *Allowed to have more than one response	Black/African American	58 (87.9%)	152 (86.9%)	95 (92.2%)	0.38
	Hispanic/Latino	2 (3%)	9 (5.1%)	1 (1%)	0.18
	White/Caucasian	0 (0%)	4 (2.3%)	2 (1.9%)	0.47
	Other	2 (3%)	12 (6.9%)	2 (1.9%)	0.13
Age of Missed Clinic Visit	2 months	7 (10.6%)	29 (16.6%)	21 (20.4%)	0.71
	4 months	17 (25.8%)	45 (25.7%)	23 (22.3%)	
	6 months	15 (22.7%)	42 (24%)	21 (20.4%)	
	12 months	27 (40.9%)	59 (33.7%)	38 (36.9%)	



## Results

When asked, "Is there another reason you missed the visit?" respondents echoed similar themes to the survey responses. Several articulated fears about COVID-19 exposures in the clinic; parents were concerned about the patient's risk of exposure and possible spread to others at home with high-risk conditions, including asthma. There was also a misconception that only emergency services were available, not preventive services, which was mentioned by more than one respondent in the open-ended response. Parents also reported receiving mixed messages about which appointments were being prioritized for in-person visits. More than one parent cited concerns about possible "experimental exposure" to COVID-19 or to a COVID-19 vaccine without parental knowledge or consent. Difficulty with balancing responsibilities, including virtual school schedules, was also mentioned by more than one parent.

## Conclusion

The leading concern from parents was exposure to COVID-19. Parents received the message that going to public spaces increased the risk of COVID-19 exposure, and this study shows that parents viewed the pediatrician's office as a high-risk public space. The eligible respondents were overwhelmingly representative of a community with higher burden of disease which may have increased perception of risk. Inconsistent messaging about types of services available contributed to decline in preventative visit compliance. To many respondents, it was not clear that non-emergency medical offices were an essential business. Improved communication between parents and the providers of medical services is important to improve compliance with well visits.

Results, although limited by small sample size, volunteer bias, and recall bias, show that addressing real and perceived threats of COVID-19 infection and clarifying recommendations from trusted institutions are necessary to avoid future gaps in care, especially for communities with disproportionate COVID-19 disease burden.

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