Maternal Child Health and Emergency Preparedness and Response Collaboration

The Views from Local Health Department Staff Who Support Pregnant and Post-partum People on Their COVID Response: Findings from Focus Groups

This report was prepared by the
Center for Public Health Innovation at CI International for NACCHO

Authors:

Yvonne Kellar-Guenther, PhD
Liza Creel, PhD
Marci Sontag, PhD

Thanks to Stacey Quesada for assistance with editing the report.
Thanks also to the public health professionals who took part in the focus group as well as the professionals who have provided services to their communities during COVID.

Date of Report: November 11, 2021

Table of Contents

Introduction and Methods

Between September 28th and October 12th, 2021, the Center for Public Health Innovation at CI International (CPHI) conducted three focus groups for the National Association of County and City Health Officials (NACCHO). A total of 32 people responded to NACCHO's email request and expressed interest in being part of the focus groups. Of these, 28 were invited to take part based on their availability. A total of 18 public health workers representing 13 local health departments (LHDs) actively participated in virtual focus groups held using Zoom Video Communications, Inc. ("Zoom"),. The focus groups were coordinated and scheduled based on the type of LHD in which a participant was employed. There were:

- S — 7 participants in the Small LHD (Rural, Suburban) group
- M — 6 participants in the Mid-sized LHD (Urban, Suburban) group
- L — 5 participants in the Large LHD (Urban, Suburban) group

The goal of each focus group was to understand participant perspectives on needs among pregnant and post-partum persons and parents of young children during COVID. Participants were asked questions about the perceived needs, how the LHD identified those needs, how those needs were met, and policies that had to be considered when meeting those needs. Participants were also asked about which services were and/or should have been prioritized in their LHD's COVID response and how they felt about their LHD's COVID response. Finally, participants were asked about major lessons learned.

Each focus group was led by a facilitator and supported by a note taker, both from CPHI. NACCHO was present for all focus groups. All focus groups were recorded using Zoom and the audio files were transcribed. Two coders used the transcripts to identify themes using NVivo.[1] The notes taken during the focus groups were used as a reference when the transcript was unclear and, for one focus group, the chat conversation within Zoom was coded for additional themes because that group mentioned some things only in the chat. While the conversations within the focus groups were robust and insightful, only three focus groups were held and each group had participants from different sized LHDs. As a result, one limitation of this project is that we were unable to reach saturation of themes. All comments mentioned by participants are represented in the report or in Appendix A. An idea may have been mentioned by one person or by a few. In the analysis presented below, we begin with themes mentioned by multiple groups or multiple people in a group and note from which group the idea came.

[1] QSR International Pty Ltd. (2020) NVivo (released in March 2020), https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Overarching Themes

There are a few overarching themes that were present across multiple participants and LHD settings. These are:

- While the questions were focused on identifying the needs of the populations the LHDs serve, participants did note concerns for the public health staff and their families. Safety, health fears, and the stress around COVID deployment were all mentioned.
- In line with the previous theme, it was clear that in many cases, even when they were redeployed to the COVID response, staff did everything they could to continue serving clients. Strategies identified to meet MCH client needs while also focusing on COVID work included working longer hours or nights, working with other agencies, and/or being innovative in their approaches to their MCH service delivery.
- Communicating directly with clients and connecting with families was a strong theme throughout the focus group discussions. Participants mentioned that the direct communication was a strong mechanism for support in lieu of delivering in-person services. Participants also discussed a variety of ways they connected with families during their community's initial COVID response.
- LHD breastfeeding programs demonstrate the diversity of approaches to the LHDs' COVID response. In some LHDs a breastfeeding program was stopped; in others, this program continued but was delivered using telehealth. Some noted that the program was difficult to administer, while others noted it was easier to encourage breastfeeding because the new parents were at home with their infants and did not have to overcome barriers like pumping at work, which can deter breastfeeding.
- Concerns related to client mental health needs were persistent across focus group discussions, even for questions not directly related to mental health. The mental health needs specifically identified were substance use, child neglect, social isolation and post-partum depression, and depression in general.

The sections below further summarize these and other identified themes, organized primarily around the questions asked during the focus groups.

Concerns/Needs of Public Health Staff

Following introductions, participants were asked "what one word would you use to describe how you felt as you were supporting pregnant and post-partum people during the pandemic?" As shown in Figure 1, more than half of words used to describe how the LHD participants felt about their response were negative (red). Overwhelmed was the only term mentioned more than once; it was mentioned a total of three times and by two groups. This emphasis on the negative fits with the research findings that COVID-19 has led to anxiety, depression, burnout, and poor physical health for public health

workers.[2] The mid-sized LHD group had a balance of positive and negative terms while the small and large LHD groups had more negative and neutral terms.

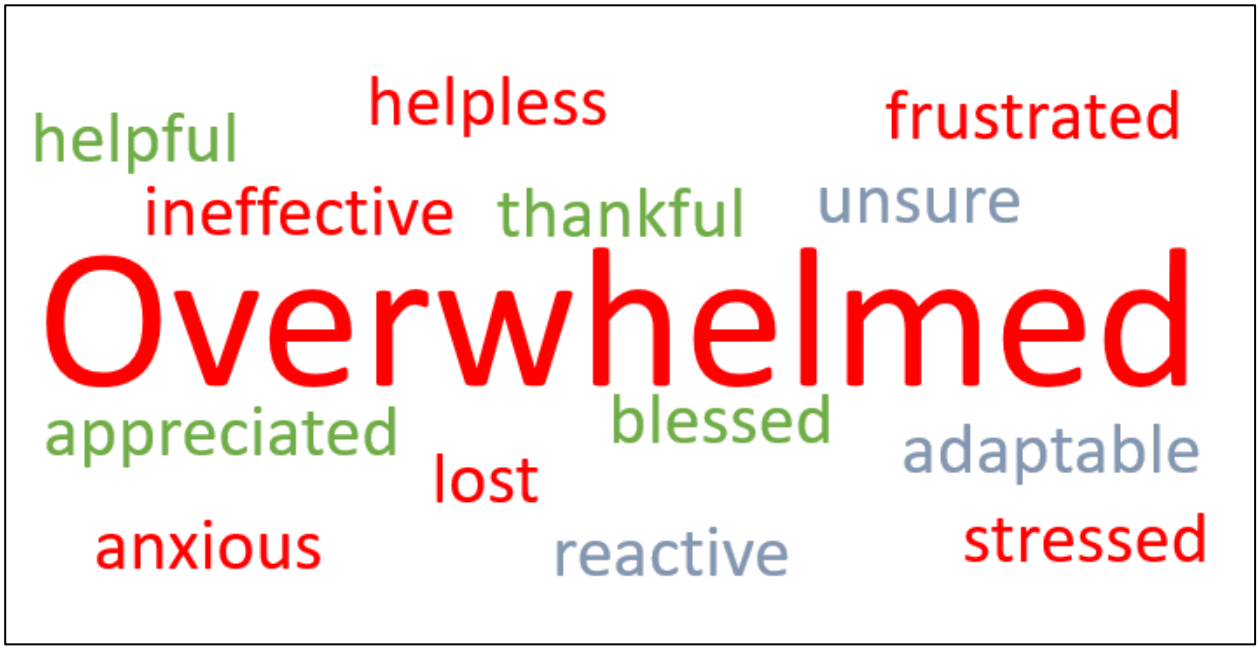

Figure 1. Word cloud showing the one word focus group participants used to describe how they felt while supporting pregnant and post-partum people during the pandemic. (RED font indicates negative connotation, GREEN font indicates positive, and BLUE reflects neutral terms)

It is possible this question encouraged the focus groups participants to talk about the impact of their LHDs' COVID response on themselves and their MCH colleagues instead of how they felt about service delivery during COVID.

MCH Staff Redeployed to COVID Response at the Expense of their Programs

As stated earlier, participants did note concerns for the public health staff , their needs and the needs of MCH populations they normally served. Perhaps the biggest concern was being deployed to the COVID response and, as a result, not working on their programs and with their populations as usual. One particular area of interest for the focus groups was learning how LHDs prioritized programs, recognizing that they had to make difficult decisions about where to spend limited resources while responding to the pandemic. During the focus groups, when we asked about which programs or services were prioritized during COVID, the most common answer was that some MCH programs stopped (small, mid-sized & large). LHD staff also noted that MCH staff were part of their LHDs' COVID response (small, mid-sized & large). In some cases, this meant stopping or limiting their usual services to clients, even if the MCH program was not officially closed. "That's what I ended up doing. I ended up running the hotline instead of being a lactation consultant. So, I was not helping people, not in the way I'm used to." (mid-sized LHD group)

[2] Stone, K. W., Kintziger, K. W., Jagger, M. A., & Horney, J. A. (2021). Public Health Workforce Burnout in the COVID-19 Response in the U.S. International journal of environmental research and public health, 18(8), 4369. https://doi.org/10.3390/ijerph18084369

The COVID deployment made some LHD participants feel as though they could not meet the needs of pregnant and post-partum people in their community (mid-sized LHD group). In some cases, the programs kept running, but staff spent a lot less time on them (mid-sized, large).

> "Our programs continued, but obviously COVID was prioritized. And so my nurses were spending, or my staff was spending quite a bit of time in COVID activities." (mid-sized LHD group)

> "Actually, you know, a lot of our teams are pulled to actually do COVID work because we're working with the health department when you're considered first responders. So we had to find ways to handle what we were doing as positions with pandemic and then still address the needs of our clients." (large LHD group)

Minimizing the MCH programs increased the stress of the MCH staff. A few respondents mentioned that they took it upon themselves to do their MCH work in addition to the COVID work, often after hours.

> ". . .Although it's public service, I felt so torn because I care about my entire community, but I was so worried being pulled [into COVID response]. I was worried about our moms. Because . . . any amount of missing a call… could just be detriment… because sometimes they call and could be in a situation where domestic violence is an issue… a lot of times what I would end up doing is just checking on them even in the evening, or like on a weekend or something like this, because I have that in the back of my head. And again, I felt torn. It wasn't that I didn't want to service my community. I realized that the oath that we take, the public service and when it's a pandemic, we all come together. . . So I did feel torn. I will be honest about that." (large LHD group)

> "Lactation never went away, I was one of the only people that never missed a day and was going 15 days straight at times and it didn't matter if I was going to see that person at seven o'clock at night because I was still at work, working on contact tracing and I was going to meet them when nobody else was in the health department so that they felt secure." (small LHD group)

While some of these programs restarted by the time the focus groups were conducted, others did not. A few participants in the small and mid-sized LHDs mentioned that car seats programs were still not running when the focus groups were conducted. A participant from the large group also said that MCH services have not started up again as of the date of the focus group. The small LHD group identified more programs that were stopped (n=5) due to COVID vs the mid-sized (n=2) and large group (n=2). Specific programs that were stopped included:

- MCH programs (small, mid-sized & large)
- Car seat programs (small, mid-sized & large)
- Breastfeeding/lactation programs (small & mid-sized)
- Local home visiting program (mid-sized)
- Prenatal support (small)
- Safe sleeping (small)
- Substance exposed newborns (small)

> ". . . our car seat programs just essentially stopped. And there's a local home visiting program that they were still going and doing some car seat fittings like at the home, but we're not

supposed to just give out car seats without installing them. And so, I think once or twice, we dropped off car seats for people who were in a desperate situation. But otherwise, that just stopped." (mid-sized LHD group)

"I feel like our department didn't prioritize pregnant people. We normally have 10 home visitors and two supervisors, and then a supervisor and five people working on systems, level, maternal, child health, none of our maternal child health people have returned to service yet. So they are still in pandemic response." (large LHD group)

"We were not able to capture [mothers who just gave birth] as much and because I wasn't able to go to the hospitals, like I was previously, I wasn't able to catch them early on, so it was a lot of just people giving up [on breastfeeding] because what's the point?" (small LHD group)

Two focus group participants were asked which programs should have been prioritized but were not. This list mirrors the list of programs that were stopped (above). They include:

- MCH services in general (large LHD group)
- Breastfeeding (mid-sized LHD group)
- Services for pregnant moms (large LHD group)

A few participants in the small LHD group mentioned that their state focused on the non-MCH population during COVID.

It is interesting to note the factors that went into decisions regarding what programs would be sacrificed to support staff COVID deployment versus those programs that would continue as usual. l A few participants provided insight into why public health programs and program staff were treated differently. They stated that LHDs considered various factors, including statutory requirements and impact on the population, when prioritizing programs and services that would continue as usual during the LHD's COVID response.

". . . I also manage the TB clinic, those staff were not pulled, because that's something that we have to do as a health department. We have to provide the TB control. So that staff was really, maybe we pulled three once or twice, but they pretty much stayed at the TB clinic and did their work there, versus the home visiting because we're not mandated to provide home visiting services." (mid-sized LHD group)

"All of our programs were open because they were considered essential, even though the doors were locked out front." (small LHD group)

Health and Safety Concerns

While many focus group participants expressed dismay that they were unable to offer services at the desired level during the LHD COVID response, a few participants highlighted safety and health fears amongst themselves and their public health peers who provided in-person services during COVID. A few respondents mentioned that when services were reopened, some public health responders were not comfortable going into clients' homes because of fears around COVID.

"I was actually glad that I couldn't do home visits, because then the decision wasn't mine, because I didn't want to bring something home to my kids. Whereas typically, I love doing home visits." (mid-sized LHD group)

> "I had some difficulty actually once our restrictions lightened a little bit to get that team [home visiting nurses] to really feel comfortable going back into people's homes or having an outdoor visit and being told . . . They often asked me over and over again for clarification about how safe it might be if they did that, and it was interesting because I thought they would want to get back into that one-to-one in-person contact really soon… but in our health department if anybody got sick or brought the virus to our office, the whole place could have closed down easily because we're so small. And I think the stress on them to have this COVID face and do all this COVID work, it really imprinted on their psyche, and so I found them to be somewhat inhibited in terms of loosening the restrictions to get back in touch with the families." (small LHD group)

Another concern that came up at least once is the negative public perception of the public health COVID response. ". . . I also feel like community response . . . which I have to say one of the impacts for me and rural public health and a small place where everybody knows each other, is that the divisiveness over the issue of the pandemic and how to do things to help curve it are very violent here. It's very, it's very polarized. We've had our health officer threatened. She's also a single mother, fairly young position. Who's our county health officer. So it's not been easy" (small LHD group). This did not come up often in the replies, but of stories of this type of response are widespread in the media.[3]

How Participants Rate LHDs' COVID Response and Why

Many of these concerns mentioned above arose when we asked focus group participants to rate their LHD's ability to support pregnant and post-partum people (See Table 1).

Table 1. How Groups Rated their Local Health Departments' COVID Response for Pregnant and Post-partum People

	Small	Mid-sized	Large
Poor	0	2	0
Okay	1	2	2
Good	2	2	2
Excellent	2	0	1

What Negatively Impacted Their Score

Participants said they scored their LHDs' response low because (1) there was no support for the pregnant or post-partum people (small and mid-sized LHD groups), (2) the MCH population was not a priority for their LHD (small LHD group), (3) they felt the staff being deployed away from their daily MCH work to help COVID negatively impacted the groups they normally worked with (large LHD group), and (4) staff retired during COVID and it became difficult to replace those staff (small LHD group), which increased workloads or the work just could not get done.

> "I selected poor, because . . . we shut down, and that's all we had was COVID, 24/7. So if you could make a call, great, if you didn't, they just got mailed a packet."

[3] https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/08/05/the-pandemic-has-devastated-the-mental-health-of-public-health-workers

What Positively Impacted Their Score

Being able to continue to offer services (small LHD group), even after hours or in addition to the COVID work, was viewed positively. However, it should be noted that those restrictions—doing MCH work in addition to COVID work or after hours—resulted in a "good" versus "excellent" response. The collaboration with their co-workers and collaborators also informed a "good" or "excellent" score. Having partners who could provide support to pregnant and post-partum people (mid-sized LHD group) resulted in choosing "okay" versus "poor." One person noted that the staff had to be innovative in delivering services and appreciated that chance for innovation (small LHD group). The ability to retain staff was also important and resulted in an "excellent" score. One LHD participant stated that offering services online rather than in-person or not at all was beneficial (small LHD group). Finally, one participant noted their LHD director was supportive of staff and rated their LHD response as "excellent" (small LHD group).

> "I [rated LHD response as] excellent. And the reason being is our services, as far as helping pregnant and post-partum women, never stopped. We never locked our front door or anything like that. So if they needed diapers, we found them diapers. If they needed food, we found them food. Like I said, all of those needs of high-risk needs, that were there before the pandemic were there during the pandemic. So we never really changed how we operated. So yeah, our service continued, unaltered really by the pandemic." (small LHD group)

> [choose rating because] "through our partnerships that we were able to at least do something and have referral, people to refer to, providing information, making sure that they knew about the COVID vaccine." (mid-sized LHD group)

> "I really feel that our director was very pivotal in how we were able to adapt." (small LHD group)

Concerns for the MCH Population During COVID

The focus group questions were designed to capture what LHDs perceived to be the needs of pregnant and post-partum people and families with young children. The participants were asked what the needs were, how they identified those needs, and how they met those needs. Participants were also asked about mental health needs and the access to doulas.

Identified Needs of the MCH Population During COVID

Respondents identified specific needs of the MCH population during COVID. The large group identified the most needs (n=22). The small and mid-sized groups generated a similar number of needs (n=13, 14 respectively). Basic family needs, ability to get medical care, basic baby care, and the need for accurate COVID information were the needs mentioned by at least two groups.

Basic Family Needs

Basic family needs were the most frequently mentioned needs LHD MCH staff identified for the populations they serve, with food, childcare, and internet connectivity being some of the most common concerns. Basic family needs were mentioned by at least one participant in all groups. The examples given were:

- Food (small, mid-sized, large LHD groups)
- Child-care (small & large LHD groups)
- Internet Connectivity (mid-sized & large LHD group)
- Employment (large LHD group)

- Housing (large LHD group)
- Phone minutes/texting data (mid-sized LHD group)
- Safety (large LHD group)
- Transportation (large LHD group)

> "In [our] County, it was mainly food and how to get food during the pandemic. That was one of the main requests needs that we got many times from our partners on how we could guide people to getting food and food services." (mid-sized LHD group)

> "We actually had a food pantry shut down during the pandemic. So food security has always been a big issue as well." (small LHD group)

> ". . . our pediatric patients who had older siblings that now they're home from school or no daycare or whatever could not come to the appointment if it was in person, because you're only allowed the mama or the poppy to go with the baby . . . I had a couple of babies that miss the whole lot of the basic series of their vaccines because they couldn't go in because, you know, there are kids in tow." (large LHD group)

The need to access the internet was essential for all populations during COVID. Research shows this need most often affects communities of color and lower-income families.[4]

> ". . . for moms to try to get social security numbers for their babies, their social security numbers cards for their babies in order to enroll in services, the office went virtual, it went remote . . . everything was being done online. So challenges of them having access to like computer or anything internet in order for them to transition from being able to take a bus or to have a ride or someone to take them there in person to transitioning to online, and the length of time it would take for them to get the services they needed, or the turnaround time . . . it was definitely challenging for those that did not have internet access or computer access to be able to keep up with the world that was transitioning to virtual." (mid-sized LHD group)

One basic family need was safety. Domestic and community violence[5] increased during the pandemic.[6,7] Research shows that communities of color have been disproportionately affected by violence during COVID.[6]

> "One of the differences that occurred during the pandemic that wasn't pandemic related was violence related was during this time of violence against the murders of our other community members, but community members at large. That continues and our parents were quite distressed, and we're still trying to gain from that some sense of resilience, but it's going to be remembered as part of the pandemic, even though it wasn't COVID related in itself. So, I just

---

[4] https://www.pewresearch.org/internet/2020/04/30/53-of-americans-say-the-internet-has-been-essential-during-the-covid-19-outbreak/

[5] https://everytownresearch.org/report/gun-violence-and-covid-19-in-2020-a-year-of-colliding-crises/

[6] Naghizadeh, S., Mirghafourvand, M. & Mohammadirad, R. Domestic violence and its relationship with quality of life in pregnant women during the outbreak of COVID-19 disease. *BMC Pregnancy Childbirth* **21,** 88 (2021). https://doi.org/10.1186/s12884-021-03579-x

[7] Kotlar, B., Gerson, E., Petrillo, S. et al. The impact of the COVID-19 pandemic on maternal and perinatal health: a scoping review. Reprod Health 18, 10 (2021). https://doi.org/10.1186/s12978-021-01070-6

want to add we had that whole thing going on and still continues today either through racism or through the widespread violence that continues in [our community]." (Large LHD group)

Ability to Get Medical Care

Participants said that pregnant and post-partum people and newborns needed to be able to get to medical care either in-person (small and large LHD groups) or online (large LHD group). Some reports state that groups of color experience more difficulty accessing healthcare prior to COVID and during COVID.[8,9] The difficulty getting to medical care online goes back to the need for internet connectivity and phone/texting minutes (large LHD group), while the difficulty getting to medical care in-person was just that providers were not seeing in-person patients during COVID (large LHD group) or transportation (large LHD group) was difficult. Two participants in the large group mentioned the difficulty in getting needed medical care was related to families not understanding the process for scheduling follow-up visits after a virtual appointment; something that is easily done in the office after a physical visit to the doctor. "Especially my Spanish-speaking clients, when they got off telehealth, they'd end the phone call. And normally when you were in a clinic, you'd go to the front desk, and you'd schedule your appointment. Well, that appointment scheduling was never happening. And so a lot of my Spanish-speaking clients just didn't know when their appointment was. They said, 'Oh, my doctor will tell me, my doctor will call me'. . . a lot of missed and trouble following up with appointments" (large group). One participant mentioned that not everyone in the community wanted to go to in-person doctor visits. ". . . our moms were fearful to go to those appointments. Being that you associated catching COVID with going to a doctor's office" (large group). This inability, or in some cases unwillingness, to get medical care was important because LHD focus group participants felt it was important for someone to be monitoring both mom (mid-sized and large LHD groups) and baby (large LHD group) to make sure their health needs, including mental health (small LHD group), were being met. One research study found first antenatal visits dropped 26% during COVID.[10]

Basic Baby Care

Basic baby care was also mentioned as a need but it was mentioned about half as often as basic family needs. Like basic family care, these were often everyday needs. The only need mentioned by more than one person was diapers and wipes (mid-sized and large LHD groups). The other examples given, each only mentioned once, were:

- Baby clothing (mid-sized LHD group)
- Baby bathtub (mid-sized LHD group)
- Formula (large LHD group)
- Safety items like car seats (mid-sized LHD group)

[8] https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/

[9] Whipps, M.D.M., Phipps, J.E. & Simmons, L.A. Perinatal health care access, childbirth concerns, and birthing decision-making among pregnant people in California during COVID-19. BMC Pregnancy Childbirth 21, 477 (2021). https://doi.org/10.1186/s12884-021-03942-y

[10] das Neves Martins Pires, P.H., Macaringue, C., Abdirazak, A. et al. Covid-19 pandemic impact on maternal and child health services access in Nampula, Mozambique: a mixed methods research. BMC Health Serv Res 21, 860 (2021). https://doi.org/10.1186/s12913-021-06878-3

". . . some other things that they also always need are just baby items; clothing, bathtubs, car seats, those kinds of things, but not specific to the pandemic." (mid-sized LHD group)

A few respondents said that basic baby care needs were not specific to the pandemic, these were ongoing needs; the pandemic just made it more difficult to get the resources to the family.

". . . because we have a diaper bank that they're [public] supposed to come [to the diaper bank] and get them. And so in one of our offices, we were doing remote that they would call, bring it downstairs, put it on the picnic table, so that they would get it. And then in a couple of cases where a parent was quarantined or isolated, we would drop diapers off at the house." (mid-sized LHD group group)

Need for Accurate COVID Information

Unlike some of the other needs mentioned, the last need mentioned by at least two groups was COVID specific—the need for accurate COVID information. This was difficult because information and guidance was changing, but the LHD participants did note that providing accurate information, when possible, was important. They also noted that they themselves were unsure in some cases because of changing guidance and that made it difficult for them to provide care.

"I think my pregnant moms and their families were most concerned of, and that's where I was unsure, how can I advise them as to what is healthy and safe for a woman during COVID times?" (large LHD group)

"And they're still like, anxious about something and, you know, then maybe I'll see they're in scrubs and may I ask what you do and where do you work? And, then that will kind of unfold where the fear of I can't do this or I can't manage, or like I had one mom just say, I'm scared to pump at work because what if something happens with my milk and that's how it's transferred, or there's just a lot of misinformation that was going around. And a lot of people were just scared, just scared." (small LHD group)

Other Needs Only Mentioned By One Person

Three participants each identified one need that no one else mentioned. The first of these was addressing substance use and maltreatment of children (small). While only mentioned by one person initially, mental health needs was a theme that came up in response to other questions and in the published literature. Substance use among pregnant women was also mentioned in the media as an issue.[11,12,13] The other needs mentioned include:

- Mom's need for hygiene products (mid-sized LHD group)
- Help keeping families together in hospital if one has COVID (large LHD group)

Doulas

One area of particular interest for NACCHO was the need for and use of doulas during COVID, and there was a question related to this in the focus groups. Though few participants commented on doulas, one

[11] https://www.verywellhealth.com/pregnancy-substance-use-disorders-during-covid-19-5116371
[12] https://www.healthaffairs.org/do/10.1377/hblog20210218.847791/full/
[13] Kotlar, B., Gerson, E., Petrillo, S. et al. The impact of the COVID-19 pandemic on maternal and perinatal health: a scoping review. Reprod Health 18, 10 (2021). https://doi.org/10.1186/s12978-021-01070-6

participant in the small LHD group did say that she felt like it may have been easier to have a doula because of telehealth.

> ". . . when asking them about like doula support or their birth experience, many of them mentioned like, 'oh, I had a doula, you know, either she was present or I had someone who was, video chatting with me throughout the whole thing.' So for some, it was more assessable because it was virtual or for others childcare is an issue . . . those who maybe didn't have opportunity to get an in-person doula, were able to get someone who would virtually support them. And I think that for some doulas, they said that they saw an increase in how many clients that they were seeing." (small LHD group)

A few in the mid-sized LHD group felt doulas were not really a need for their population but someone else in this group stated the low use in her community may be because of the cost. The small LHD group also stated cost was an issue; they noted Medicaid does not cover the cost of having a doula. Of note, this barrier to doula care is potentially unrelated to COVID.

> ". . . I was kind of hoping that with the virtual, we would be able to do that, but with 70% of our moms or pregnant people on Medicaid, that was not an option because we had no doulas approved to work with our Medicaid program." (small LHD group)

> "I would say in my area, people would do it if they don't have to pay out of pocket, but the cost is prohibitive." (mid-sized LHD group)

Identifying Needs

NACCHO's interest in needs extended beyond what the needs were to how those needs are identified. Strategies for identifying needs helps provide insight into how the LHDs work with their communities and how communities with high social disparities are included in MCH service provision. The mid-sized LHDs had the most variety in how they identified needs (n=11), followed by the large (n=7), and small LHDs (n=4). Communicating directly with families was mentioned most frequently as a method for identifying a need and for ensuring families had access to services or supports to meet those needs.

Talking Directly To or Observing Families

Interacting directly with families appears to have been key in identifying and meeting the needs of the communities served by the MCH program. Both the mid-sized and large LHD participants mentioned they called families directly to find out what they needed and to ensure their needs were being met. Additionally, LHD participants in all three groups said they heard about or observed family needs as part of delivering care (new clients, existing clients, online, home visits) (small, mid-sized & large LHD group). When looking at the data, it appears as though the LHD employees prioritized enhanced communication (direct or indirect) with families to make up for more limited in-person services.

> "I think asking them, in addition to doing one-on-one individual consults, I was also doing the group and so that was kind of like a forum for me to kind of identify reoccurring themes [of needs]." (small LHD group)

> "I think for our families, it was just basically what they were able to observe or elicit through the home visits. NFP does have its screening tools, and we do ask some questions, we develop some for other programs as well." (mid-sized LHD group)

> "No, we were not doing home visits at all, actually. But they would call us . . . we made virtual zooms more available for them, for every class, for every enrichment class, for everything, even if doing one-on-one breastfeeding sessions, things like that . . . Most of us on our team have work cell phones. So giving them, having them have access to that number and just letting them being able to call us to let us know what their needs are . . ." (large LHD group)

In some cases, the LHD heard about the needs when families reached out to LHD programs to ask for help (small, mid-sized & large). However, it should be noted that not all families knew that services were even being offered; the large group mentioned that some clients just assumed public health programs were not available during the initial COVID response.

> "So for us, it was mostly self-referrals, so people would have to reach out to me." (mid-sized LHD group)

> "How we heard about this depletion of resources was from the stories from our current and probably some of the former memberships that would call us." (large LHD group)

> "They may, you know . . . reach out, you know, 'I'm not able to get groceries. Do you know of any, you know, churches that are doing food drives right now', or 'I need diapers or, 'you know, my anxiety is crazy right now. Do you have time to talk?' So a lot of it just came straight from the clients as far as their needs . . . you know, working with my clients, it was primarily them who expressed what they needed. They came to me and told me what they needed." (small LHD group)

One participant noted that the city responded to feedback around the COVID vaccine to ensure that all populations, including populations with health disparities, had access.

> The city really tried to make sure everybody [had access to the COVID vaccine] . . . and they're still listening and hearing, 'Oh, we didn't get here, we didn't do this, okay we're coming'. . . we offered vaccine information sessions where our clients could ask whatever myths they thought, questions they had, and we had an expert come in and just talk to them . . ." (large LHD group)

The LHD participants talked about getting the word out so families could reach out to them. "I did contact all of our breastfeeding supporters in the area, and I put out a Facebook post with phone numbers, so that they could call someone" (mid-sized LHD group). In addition to social media posts, the use of mass emails was also mentioned as an example of one large LHD ensured they were meeting the needs of their community. One participant said their LHD used a more passive approach – posting information on their website; they felt this increased accessibility to needed resources (mid-sized LHD group).

It does seem that some LHDs may not have changed their strategies for assessing client needs, while others did. For example, one participant said they did not change how they gathered information on needs during COVID, whereas another participant said they did have to change how they obtained accurate information on client needs; both were in the mid-sized group.

Other Ways LHDs Identified Needs, Mentioned by One Participant

Three other ways to identify needs were mentioned once. These include:

- Referrals from hospitals or physicians to LHD programs (mid-sized LHD group)
- Write up in a hospital discharge summary (mid-sized LHD group)
- Communication with community partners (large LHD group)

Service and Program Prioritization to Meet Needs

As mentioned earlier, some programs stopped or were more limited when LHDs began responding to COVID. Often, MCH staff were reassigned to help with COVID. Despite that reassignment, participants in two focus groups mentioned that their MCH programs kept operating during COVID (small & mid-sized LHD groups). The small group mentioned the following programs specifically:

- Breastfeeding (small LHD group)
- Needle Exchange (small LHD group)
- All of their programs (small LHD group)

Some programs were emphasized MORE during COVID. These included:

- Services for groups with high disparities/racial equity (small & large LHD groups)
- Substance use (small LHD group)
- Transportation (large LHD group)
- Programs that addressed food insecurity (large LHD group)
- MCH programs (small LHD group)
- Supplies for families on Medicaid (large LHD group)
- Client interaction (large LHD group)
- Programs where public health depts or divisions worked together (small)

Two participants mentioned that their LHD emphasized service for groups with high disparities, substance use, and transportation barriers more during COVID. All the others were mentioned by one focus group participant.

When asked how they met the needs, LHD focus group participants mentioned two primary ways they met the needs of pregnant people, post-partum people, and families with newborns during COVID: changing how they delivered their services (to accommodate limitations of in-person interactions) and establishing or strengthening collaborations with community organizations to address the needs the LHD could not. The COVID hotline was also mentioned as an important strategy by two people in two groups.

Change How Services Are Delivered

Delivering services online or remotely (small & large LHD groups) and directly delivering services or goods/materials in-person to the family (mid-sized & large LHD groups) were mentioned most often as examples of how the LHD changed service delivery when in-person interactions were limited due to COVID. ". . . virtual support was something that I will say came out of that, which was a beautiful thing out of a really stressful time" (small LHD group). One type of service delivered online was education, including education around how to use telehealth services (small & large LHD groups). Education around what care was needed was also mentioned. A participant in the mid-sized LHD group said that encouraging and educating families to get appropriate care was an important way to ensure everyone has access to needed resources. Another participant in the small LHD group mentioned they offered "virtual parenting like feeding and parenting support group".

Home visits specifically were mentioned frequently as an important MCH service for pregnant and post-partum people as well as new families. Someone in the mid-sized LHD group noted that home visitation is one way to ensure access to care for everyone. Small and large LHD groups stated that one change they made during COVID was to deliver home visits online. Lactation education and support groups were also services that were mentioned as being delivered online .

> "So we continued doing visits at the time of the pandemic. We had 124 clients and 10 nurses, and two nurses took over the 124 clients and did telehealth during that time. So we heard directly during, we continued our every other week visits, mainly via video." (large LHD groups)

> "But during the time that we had our first shut down and we've had quite a few of school shut down, and parents home from work because they couldn't go, we instituted our group connections in the daytime. This is a parent as teachers group and the group connections were story times for the kids and the parents was singing along with the babies." (large LHD groups)

Sometimes delivery of services online was not enough. In those cases, the LHD would drop off needed items and educational information/material to families. This was not only mentioned as a way to meet the needs of the community but also as a way to ensure access to services for all pregnant people, post-partum people, and families with newborns in the community (mid-sized and large groups). "We could do door drops and see people outside, but we couldn't go into homes" (large LHD group). The most common examples were dropping off family or basic baby needs.

> ". . . we do have some diapers. So if necessary, our nurses did drop-offs." (mid-sized LHD group)

> ". . . one of the biggest needs, again, was food. So we worked with our food banks here, had someone go and pick up the food, and then again, drop it off at the door for somebody." (mid-sized LHD group)

Another direct delivery resource mentioned was educational materials.

> "In terms of like educational information that we provide through our programs, initially, again, we were having the nurses just drop those off. And then we set up a dedicated email, where people could not respond to that, that they could use that to email forms to families, and then specifically Nurse Family Partnership started to do that from their system to our families. So that's how we got some educational materials out that supplemented the education that we provide." (mid-sized LHD group)

In addition to delivering services differently, LHDs changed their service protocols and, sometimes, mechanisms. They kept cases open longer (large LHD group), started screening regularly for mental health needs (small LHD group), and made themselves more accessible to clients using technology (text, video, etc.) (small LHD group).

Working with Community Organizations To Meet Needs

The second most frequently mentioned approach to addressing needs was working with community organizations. This was also mentioned by all 3 groups (small, mid-sized & large LHD groups). One participant noted that the pandemic made it easier to find and work with partners.

> "And then the last thing I want to say is for me, what this pandemic has shown me is that no longer can we use the excuse that humans can't come together and be kind to one another and no longer can we use the excuse that we can't find resources. So, it kind of made me look at different partners and stakeholders and other organizations like, ah-ha, I got you. You do have that resource. And I know that you know how to use it now, kind of like that. Not to be negative or anything, but I'm just saying where I couldn't get you on the phone, now I know I can get you on the phone during the pandemic." (large LHD group).

Community partners helped to deliver services and supports to meet babies' and families' needs. For example, community partners helped provide items for babies such as clothing and cribs (mid-sized LHD group). These partners also helped meet the broader family needs. They provided educational information (small & mid-sized LHD groups), internet connectivity for families (large LHD group), and mental health support (small). It is interesting to note that the three groups all noted a similar number of partners (small n=9, mid-sized n=11, large n= 9). All the partners mentioned are in Table 2.

Table 2. Community Partners Specifically Mentioned During Focus Groups.

Larger Category (most to least frequent)	**More Specific**	**Focus Group**
Community support groups	Churches	Small
	Community Action Network	Small
	Domestic Violence Support Services	Large
	Food banks (most frequently mentioned)	small, mid-sized, large
	Foundation who provided tablets	Large
	Homeless coalition	Small
	Salvation Army/Goodwill	Small
	United Way	Small
Health and public health partners	Mental health providers	Large
	Physical health providers	mid-sized
	Public health partners	small, large
MCH focused groups	Agencies focused on services for babies and young children	mid-sized, large
	Breast feeding supporters	mid-sized, large
	Parent support (not specific)	large
	Parents as Teachers	mid-sized
	Visiting Nurse/Nurse Family Partnership	mid-sized
Medicaid managed care		small, mid-sized
Library		mid-sized
Transportation		large
Local government		mid-sized
Police and fire departments		small
Schools		mid-sized

When looking at Table 2, that the participants in the small LHD group relied more heavily on community agencies, while participants in the mid-sized and larger LDH groups may have tapped more into government-supported agencies.

COVID Hotline

The COVID Hotline, though not MCH specific, became an important way for LHD participants to meet the needs of their population, and having MCH personnel staff the hotline became important. For example, one LHD participant mentioned a new mother reached out using the COVID Hotline. "I ended up answering the phone on the hotline and dealing with a suicidal new mother. And I gave her a phone number. And that was just horrible" (mid-sized LHD group). Another mentioned that because MCH programs had stopped during COVID and because she was staffing the COVID hotline, people in the community who were otherwise unable to advise their MCH clients on COVID would suggest those in need call the hotline so she could get them the information needed.

> ". . . the state WIC department had kind of put a kibosh on us being able to talk about anything COVID [with WIC clients]. 'Talk to your physician' was all you could say. [Because] my position's a little bit different that I'm not in the WIC program . . . I was in contact tracing and COVID and still doing my regular job [helping WIC clients], so I answered our call line . . . [WIC Staff and community partners] were using my outside of the box position to get them the information they needed [having clients and community partners call the COVID hotline] because they didn't have that option through normal means . . ." (small LHD group)

Meeting the Need for Mental Health Services

Participants in the mid-sized and large LHD focus groups were specifically asked how they supported mental health needs. As noted above, the small LHD focus group listed mental health as a need, but that group ran out of time and was not asked how they supported that need. Both the mid-sized and large LHD groups felt that COVID made it more challenging to get mental health services. These groups identified two ways to meet the need for mental health support: refer for mental health services and offer LHD services to meet mental health needs.

Refer for Mental Health Services

Referrals for mental health services were the most common way of getting pregnant people, post-partum people, and families with young children into mental health services (mid-sized and large). As mentioned above, this was often done through direct communication such as asking questions to assess the need for services when meeting with and checking in frequently with clients (new and old) and then referring to mental health programs as needed (mid-sized LHD group). Not many specific services were mentioned but one participant mentioned that the area had a post-partum support group to help meet new parents' mental health needs. (mid-sized LHD group)

> ". . . 20% of the time, [the nurses] were just checking in on their moms, just seeing how they were doing. As part of our programs, we use a PHQ-9 to screen for depression . . . it's hard to do it over the phone especially when you're not seeing them and that connection . . . But we continue to do screenings as well as referrals and the nurses just did their best to just check it on them and see how they're doing. Just sometimes no education provided, just how are you doing? How's everything, is there anything I can help you with?" (mid-sized LHD group)

Provide LHD Services

As stated earlier, the small LHD group identified substance use and maltreatment of children as a need for pregnant and post-partum people. Part of this need was met by keeping or emphasizing these services during COVID .

> "We built more of our substance use treatment for our pregnant people during that time, really trying to figure out what we needed to do to make sure we were supporting them." (small LHD group)

> ". . . the only program that remained drop-in appointment was our needle exchange, which we're really proud of because we have a community that mostly accepts it and supports it. And it's really critical for harm reduction in our communities. And we do have pregnant women who come through our needle exchange. And so there was no closed door, literally. . ." (small LHD group)

It should be noted that while these services continued for adults, one small LHD participant stated that services for substance-exposed newborns stopped during COVID. ". . . we actually just had one of our first meetings for our substance-exposed newborns meeting today . . . it was like January of 2020 that we had our last meeting, so our substance-exposed newborns collaborative has definitely gone away . . . Had gone away throughout this . . ." (small LHD group)

The other way focus group participants identified they met the need for mental health services was for the LHDs to offer services that can help meet need as early as possible. Participants in the large LHD group mentioned delivering education to their clients to reduce stress as one way to meet the need. Some examples given were "we tried to do virtual yoga to try to give them ways to release stress" (large LHD group) and "We talked about just self-care. I talked about that earlier, just trying to find ways to take a minute to yourself and just to do some positive affirmations to try to mentally just gather yourself again, and then just talking about taking time away from screen and not being so drawn into what's going on" (large LHD group). Another in the same group talked about delivering services to reduce isolation. A participant in this group also discussed using social workers to meet the mental health needs of LHD clients.

> "Another thing that we were doing for clients is our social workers were keeping closer tabs . . So our entire caseload, they were meeting with them more often . . Because along with post-partum could be an issue, as well as feeling isolated." (large LHD group)

> "We focused on making sure that our clients had an interaction through some type of form of education. . . we did more of them because they were at home and isolated." (large LHD group)

Other Approaches to Meet the All Needs and Ensure Access

The mid-sized LHD group identified a few other ways to ensure access that were not mentioned elsewhere. These include:

- Connecting families to needed care, including clinical care (mid-sized LHD group)
- Determining family's insurance coverage (mid-sized LHD group)

- Providing technology (mid-sized LHD group)

Policy Considerations When Implementing Strategies

Two focus groups were asked about which policies they had to consider when implementing strategies to meet the needs of the pregnant and post-partum populations in their communities. The small LHD group said two central policies had to be considered: (1) HIPAA, the most commonly mentioned policy, and (2) figuring out how to documents signed online vs. in-person. Both of these were mentioned by more than one participant in the group.

> "It's kind of hard to articulate how many loopholes and hoops and red tape ensues when you're really just trying to get a basic thing, like a piece of paper signed when you're in lockdown community-wide . . . getting consent from clients, whether it was WIC or NFP [Nurse Family Partnership] or whatever . . . was just entirely too confusing." (small LHD group)

> "[For HIPAA] We had to come up with all these interesting subject line, they're called Dan numbers, just so we'll hide the fact that these kind of simple communications were going on. You know, we could have only relied on texts, but that's also public record. So anyway, complicated." (small LHD group)

The large LHD group mentioned different policies they had to consider. The most commonly mentioned was COVID protocols. The changing information around COVID protocols and the rules around public COVID protocols were mentioned by a few participants as policies to be considered.

> ". . . as [COVID protocol] changes, we try to educate what we know. But I think one of the difficulties with the wavering of policy is in, of course it has to because we didn't have all the information upfront, is we still don't have all the information . . . Educating people about, it is science, we don't know yet, but here's the best knowledge we have right now, right this moment and this is the safest option. It's still hard to be in that position . . . now we're starting to educate about pregnant women getting their COVID shots and what happens when you get it and who do you talk to and try to have a safe and effective message . . . I think that's the biggest problem is it evolves over time. How we have to have one consistent message, but yet it's still going to have some caveats. All those people, I inoculated with Johnson and Johnson saying, 'This is a single dose inoculation you will be getting', I am now having to eat my words to say, 'Yes, you'll need a booster'. But that didn't bother me as much as saying, 'I don't know if you're pregnant you can get a COVID shot'. Whereas now I feel much more comfortable saying so. It's very iffy and that's the part of unsure I feel." (large LHD group)

Telehealth delivery was also an issue. Participants mentioned that Medicaid reimbursement for telehealth delivery and the rules on how to use Zoom had to be considered.

> ". . . prior to COVID tele-health was not reimbursable by Medicaid. They did change that and so we are able to bill Medicaid for our visits, which is helpful. They don't pay us enough, but it's something." (large LHD group)

> ". . . here's the policy says that you can [use Zoom] in a certain manner. . . there were guidelines to how you could use zoom. You had to have it locked. You had to have it this way. You had to make sure no one could get in. Only certain people could have the code. You couldn't just send

> it out to everyone in the public. So there were little policies to me that came down that affected how we did work, that we adjusted to, then it would change and adjust to the change." (large LHD group)

One person also mentioned they had to understand the rules around using federal funds for COVID.

> ". . . some of the distribution of money that came down from the federal government was very helpful. Our department did choose to use the majority of the funding [for] community members who were experiencing homelessness or who were not able to work because of having COVID. People would get gift cards to cover some of their expenses while they were isolating for COVID." (large LHD group)

Public Response to Public Health MCH Efforts During COVID

Again, due to lack of time, only two groups – small and large LHD groups – were asked what they felt was the public response to the strategies implemented by the MCH staff during COVID.

Participants in the small LHD group felt that the services that were offered were effective. At least one participant from the small LHD group mentioned being able to get support at home (either in-person visits or online) was well received for both individual services (e.g., lactation support) and being part of a support group. The large LHD group participants felt clients appreciated the effort being made and that their clients were resilient, which the focus group participants viewed as positive.

Silver Linings

In each focus group, at least one person mentioned a "silver lining" to how the LHDs had to respond to the COVID pandemic. No questions were asked about silver linings, nor were they ever probed for. These silver linings were around how the LHDs and community met the needs of the population and increased adoption or utilization of some important MCH services.

Meeting the Needs in New Ways

A few participants noted that COVID required ". . . thinking outside the box and how could we continue to deliver services, but in a different manner." (small LHD group) The example given by this participant was the launch of "a virtual lactation app that we use, and many families have utilized" to help with breastfeeding (small LHD group). While there were some issues with the app, being able to launch and use it during COVID was helpful and they did not have to stop breastfeeding support.

The collaboration between the public health department and their partners was also mentioned as a silver lining.

> ". . . the pandemic . . . brought out the giver in more people . . . Organizations came together more. There wasn't any pushback to helping another program. And more services, to me, were able to be utilized because we opened up more to each other as programs. And you thought outside the box of what's out there, but programs also made sure that they were known to be out there. This is what we have and here it is. Someone come and use it. So, I hope that that continues and you don't have to try to search through all the haystacks to try to find these resources." (large LHD group)

A lot of participants mentioned that the use of telehealth was important in their ability to provide services, especially early on in the COVID pandemic. As mentioned above, insurance companies and

Medicaid reimbursing for those services was crucial. While many felt the use of telehealth was not ideal for some MCH services like breastfeeding support, one focus group respondent mentioned it was fantastic for providing mental health services because it overcame barriers typically seen for in-person care.

> "The telehealth [services] were great for those [who needed mental health services], they didn't have to go somewhere. They could find a quiet room and talk to them . . . I think for mental health work out. In fact, I had a lot more people utilizing that service just off the top of my head thinking they were much better at being there because they didn't have to go on the buses and they didn't have to have kids in tow and so forth." (mid-sized LHD group)

Adoption of and/or Increase Utilization of MCH Services

As shown in the last quote, another silver lining is that in some cases, more people were utilizing MCH services that were offered during COVID.

> ". . . WIC retention went way up with the pandemic largely because this sort of universal experience of the pandemic, I think it, it, somehow it brought some people out of the recesses who otherwise had fear of government, which is really contrary to what I would've expected because the government has been really, a big player in pandemic response." (small LHD group)

Being on lockdown also made it easier to breastfeed. "Can we talk about the perfect time to help people with breastfeeding when they have to be at home with their kids all the time? It's like the perfect time for it" (mid-sized LHD group). While some programs shut down their breastfeeding programs because lactation specialists were deployed to the COVID response, at least one participant who was still able to offer this service saw some success.

> "I saw a lot of families who were still breastfeeding past one [year] because they were able to be home with their babies and to kind of be more present and not stress about pumping and things that normally would have been an issue. So I feel like there was some success in areas . . .[that] didn't do well in the past, they were doing really well because they were able to be home . . ." (small LHD group).

Major Lessons Learned

Our last question to the focus group participants was asking them to identify lessons learned. All three focus groups identified major lessons learned. The mid-sized-sized LHD group identified the most but that may have been because they had more time for this question.

Lessons Around Service Delivery

There was no common lesson learned across the three groups. The most common lessons learned were trying new approaches to service delivery (small and mid-sized LHD groups) and keeping families together (mid-sized and large LHD groups). Both the mid-sized and large LHD groups mentioned the importance of keeping mothers and babies together. The mid-sized group also wanted to ensure families had access to their support systems.

Importance of Partners

The small and mid-sized groups also stated working with partners was important. They mentioned the need to keep in touch with partners (mid-sized LHD group) and having shared consent between the programs to serve clients (small LHD group).

Support Public Health Employees

Supporting public health employees was mentioned by the mid-sized and large LHD groups. They specifically stated:

- Making sure public servants have safety tools (large LHD group)
- Caring for employees – making sure the workload is not too high (mid-sized LHD group)

Communication

The final lesson mentioned by more than one person was the need for communication. Communication was identified by the mid-sized LHD group discussed the need for making sure the public got information as well as the need for unified communication.

Lessons Mentioned by One Participant

There were four other lessons mentioned; each by just one person. Those lessons included the following:

- Need to rebuild programs after COVID (mid-sized)
- Need for pandemic protocols for the MCH population (mid-sized)
- Peer counselors are very helpful (mid-sized)
- Difficulty to overcome vaccine resistance (large)

Conclusion

The passion the focus group respondents felt for their jobs, and the communities they serve was palpable. There are many lessons from the LHDs' response to COVID, especially their initial response to COVID when resources were limited. The CPHI team noted that the COVID pandemic is a good learning ground for the next pandemic and other emergencies, including when public health programs lose funding or governmental agencies have to make difficult decisions about program prioritization while still fulfilling their mission of population health and equity. The lessons learned here can inform not only a response to a pandemic or local public health crisis but any situation that calls for the reorganization of staff in a way that threatens MCH programming.

Those lessons learned include: (1) ensuring public health staff and their families are safe; (2) making sure MCH providers can continue to work with the populations, especially during a crisis; (3) recognizing that MCH providers will be innovative in meeting the needs of their service population but they will also go above and beyond so it is important to support in avoiding compassion fatigue and burn out; (4) communicating with the public, with partners, and with the families in the community is important; (5) during a crisis there is a need for clear communication around behavior recommendations and guidelines; and (6) attending to the MCH communities' mental health needs is important. While it is possible to ensure MCH services continue, despite limited resources, through the use of regulation or by classifying them as essential services, it is important to remember that having MCH staff involved in the COVID response was impactful; the COVID hotline was a place where these staff identified and met the

needs of their community. It will be important to figure out how to balance the needs of the populations served by the MCH programs and the broader community's needs not yet connected to those programs.