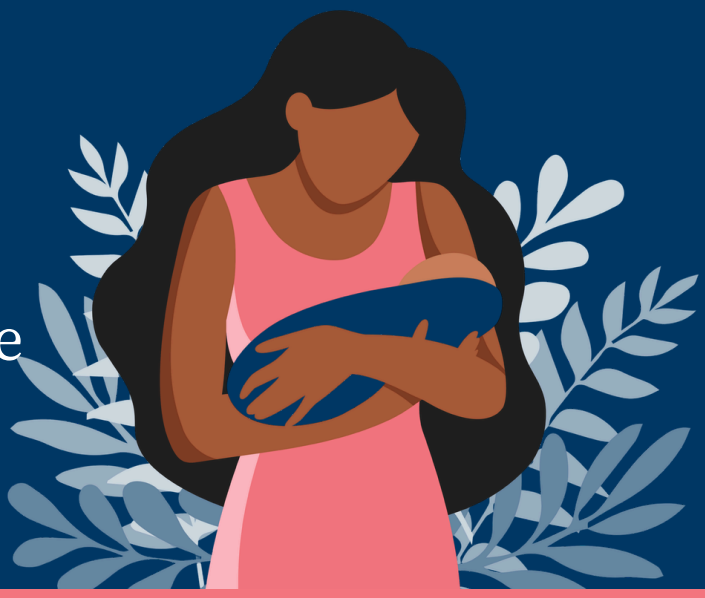
Aeroflow Health

The Silent Gap: Why New Mothers Miss Postpartum Care

And What Health Plans Can Do About It

Based on Aeroflow Health's primary research with 511 postpartum mothers across commercial and Medicaid populations.



The Gap

13%
missed their checkup

49%
of those who went felt fully supported

by plan type

Commercial	Medicaid
7% missed	17% missed

n=511 total | 211 commercial | 215 medicaid

The Opportunity

58%
would have attended a virtual visit

193
said reminders were the #1 thing that would've helped

by plan type

Commercial	Medicaid
61% virtual interest	58% virtual interest
Top need: reminders & education	**Top need:** virtual visit & ride support

Among those who missed or nearly missed their checkup

Executive Summary

The six-week postpartum visit is one of the most consequential touchpoints in maternal healthcare. It is the primary opportunity to screen for postpartum depression, address delivery complications, discuss contraception, connect mothers to social supports, and establish a care relationship that sustains long-term wellbeing. Yet for millions of American mothers each year, that visit never happens.[6]

Our 2025 primary research with 511 postpartum mothers—stratified across commercial, Medicaid, marketplace, and uninsured populations—reveals that the reasons for non-attendance are not rooted in apathy. They are rooted in access.

- Childcare
- Transportation
- Scheduling

And a healthcare system that too often places the entire burden of navigation on the most resource-constrained patients at the most vulnerable moment of their lives.

What the evidence increasingly shows is that **the solution is not to ask mothers to try harder. It is to bring care to them—virtually, proactively, and with an understanding of the social and emotional context in which they are living.** That means identifying needs before they become crises: screening for food insecurity, housing instability, and transportation barriers during pregnancy, not after. It means asking about mental health more than once. And it means designing postpartum care delivery around the realities of new motherhood, not around the convenience of the clinic.

This brief is designed for health plan medical directors, product managers, care management leaders, and quality officers accountable for postpartum HEDIS measures and maternal health outcomes. It synthesizes primary survey data with published evidence to offer a clear, actionable picture of the problem—and the care model most likely to move the needle.

The Scale of the Problem

American College of Obstetricians and Gynecologists (ACOG) recommends postpartum care begin within the first three weeks after birth, with ongoing individualized care through twelve weeks. Yet national data consistently show that 40% or more of women—and up to 60% of Medicaid enrollees—do not complete a timely postpartum visit. [1]

The consequences are severe. The postpartum period accounts for more than half of maternal deaths in the United States, with cardiovascular complications, mental health crises, and hemorrhage peaking in the weeks after delivery. [16] A missed postpartum visit is not merely a HEDIS gap, it is a missed opportunity to intervene before a crisis becomes irreversible.

> Postpartum depression affects 1 in 7 mothers. Without a postpartum visit, it goes unscreened in the majority of cases.
>
> — Cleveland Clinic, 2026 [7]

Our survey found that 13% of respondents did not attend a postpartum checkup within the first six weeks—a figure that climbs to 17% among Medicaid enrollees and 24% among the uninsured. These are not marginal numbers. They represent a concentrated population of mothers who faced the greatest logistical and systemic barriers, and who also reported the lowest levels of postpartum support across every dimension we measured.

A critical and underappreciated piece of this picture is that social needs—housing instability, food insecurity, transportation gaps, and lack of social support—are present before the postpartum visit is ever missed.

Research consistently shows that unaddressed social determinants during pregnancy predict lower rates of postpartum care engagement. [12]

Identifying and addressing those needs beginning in the prenatal period is not a separate initiative—it is a prerequisite for closing the postpartum care gap.

Why Mothers Don't Go: The Evidence

Our research identified a consistent set of barriers across all populations. These are not abstract deterrents—they are concrete, addressable problems. The data below reflects the percentage of all respondents who cited each factor as a reason for non-attendance.

1. Insurance and Network Access Failures

Finding an in-network provider was the top cited barrier for 11% of respondents—and it appeared most prominently **among employer-sponsored enrollees.** Commercially insured mothers—who might be assumed to have the fewest access barriers—are being blocked by network inadequacy. A 2022 study by Healthgrades found that OB/GYN shortages in rural and semi-rural markets mean patients face wait times up to 8 weeks for new appointments—long past the optimal postpartum window. [9] Virtual care pathways that operate independent of geography represent one of the most direct responses to this structural failure.

2. Childcare: The Invisible Infrastructure Gap

10% of all respondents—and a disproportionate share of Medicaid enrollees—cited lack of childcare as a reason they could not attend. This is a system failure disguised as a personal problem.

Additionally, a 2022 study from the National Library of Medicine found that childcare barriers were the second most commonly cited reason for missed postpartum visits among low-income mothers, and that even minimal childcare accommodation doubled attendance rates. [13] Virtual visits allow mothers to participate from home during a child's nap, while nursing, or with children present, eliminating this barrier entirely.

3. Transportation

Transportation issues were cited by 9% of the total sample and a higher share of Medicaid enrollees—consistent with decades of research on non-emergency medical transportation (NEMT) as a social determinant of care access. [17] Notably, transportation barriers are frequently identified during pregnancy but rarely addressed proactively. Programs that screen for transportation need as early as the second trimester—and connect members to NEMT benefits before the postpartum visit is scheduled—show meaningfully better completion rates than those relying on reactive referrals.

> Postpartum depression reduces the likelihood of maternal care-seeking by 40%. The care gap compounds.
>
> — Archives of Women's Mental Health, 2020 [4]

4. Awareness: "I didn't know it was important"

7% of respondents—disproportionately first-time mothers and younger enrollees—did not attend because they did not understand the clinical significance of the visit. Mothers who feel well after delivery may not appreciate that the postpartum visit addresses risks they cannot self-assess: elevated blood pressure, anemia, wound healing complications, and depression. Education delivered during the prenatal period, rather than at discharge, has been shown to improve postpartum visit completion by reducing the "I feel fine" assumption.

5. Mental Health Barriers

8% of respondents identified their own mental or emotional state as a barrier to attending. This is a tragic irony at the heart of postpartum care: the very condition the visit is designed to identify—postpartum depression and anxiety—is itself a barrier to attending. Mothers experiencing depressive symptoms are significantly less likely to seek care, less likely to follow through on appointments, and more likely to underestimate the severity of their own condition. [11]

This is precisely why periodic mental health screening cannot begin at the six-week visit. By the time that appointment is missed, a mother with postpartum depression may have already fallen out of the care system entirely. Validated screening tools—including the Edinburgh Postnatal Depression Scale (EPDS) and PHQ-9—administered at multiple touchpoints beginning in the third trimester allow for early identification and intervention before the postpartum gap opens. [3]

A Tale of Two Populations: Commercial vs. Medicaid

While the barriers are consistent across insurance types, their relative weight and the appropriate interventions differ substantially. Health plans serving both populations need differentiated strategies—not a single protocol applied uniformly.

Commercial Enrollees

Attendance rate: 93%
Top barrier: No in-network provider
Secondary: No childcare, lack of awareness
Virtual interest: 61% say yes

What would help most:

- Reminders via text, email, or call
- Childcare support or accommodations
- Education on why the visit matters
- Virtual or evening/weekend options

Medicaid Enrollees

Attendance rate: 83%
Top barrier: Transportation / childcare
Secondary: Felt okay, didn't know importance
Virtual interest: 58% say yes

What would help most:

- Virtual or home-based visit options
- Proactive scheduling with reminders
- Ride assistance (NEMT outreach)
- Childcare support or accommodations

The narrative difference is important. **Commercial enrollees are primarily blocked by system design failures—network gaps and awareness—that health plans can address through direct intervention.**

Medicaid enrollees face the compounding weight of multiple social determinants simultaneously: no transportation, no childcare, limited schedule flexibility, and lower baseline awareness of the visit's importance. [14] A single-lever intervention will not move this population. What the evidence supports is proactive, multi-touch outreach that begins during pregnancy, addresses social needs before they become crisis points, and offers care in formats that work around the realities of new motherhood.

A Different Model of Care: What the Evidence Supports

The research on postpartum care improvement is clear: passive reminders alone are insufficient. The interventions with the strongest evidence share three characteristics:

- They begin before birth
- They address social context alongside clinical need
- They meet mothers where they are rather than requiring mothers to come to care

The clinical case for telehealth postpartum care is now well-established. A 2023 study in NEJM Catalyst found that telehealth postpartum visits achieved equivalent screening outcomes for depression and hypertension compared to in-person visits, with significantly higher completion rates among Medicaid enrollees. [8] A separate study in BMJ Journals demonstrated that remote monitoring of postpartum blood pressure and symptom reporting through smartphone-based tools enabled earlier intervention for hypertensive complications. [10]

Virtual care also resolves childcare and transportation barriers simultaneously. A mother who can join a video visit from her living room while holding her infant and keeping an eye on a toddler in the next room does not need to arrange childcare. She does not need a ride. The appointment comes to her, on her schedule, in the context of her actual life.

For Medicaid populations in particular, this is not a convenience upgrade. It is a structural redesign of who can realistically access care.

Social needs screening: Starting Before the Crisis Begins

ACOG now recommends that screening for social determinants of health (SDoH)—including food security, housing stability, transportation, and interpersonal violence—be integrated into routine obstetric care, beginning in the prenatal period. [2] **The rationale is straightforward: unaddressed social needs during pregnancy predict poor postpartum care engagement.** A mother who cannot afford food or stable housing in her third trimester is unlikely to prioritize a six-week appointment—not because she doesn't care, but because her hierarchy of needs is more immediate.

The implication for health plans is equally straightforward: social needs screening cannot be a one-time intake question. It should occur at multiple pregnancy touchpoints, with warm handoffs to community resources, benefits navigation, and care coordination built into the workflow. Identifying a transportation barrier at 32 weeks—and resolving it before the postpartum visit is ever scheduled—is categorically more effective than attempting to troubleshoot it after a missed appointment.

Evidence from multi-site cohort studies confirms that mothers who received social needs screening and navigation during pregnancy were significantly more likely to complete postpartum care, independent of insurance type or income level. [18] **The screening itself, when conducted in a non-judgmental and actionable way, has also been shown to strengthen the care relationship—increasing trust and communication in ways that translate into better overall engagement.**

Periodic Mental Health Assessment: Catching Depression Before it Closes the Door

Postpartum depression affects approximately 1 in 7 new mothers, yet most screening occurs—if at all—at the six-week visit that up to 40% of at-risk mothers will not attend. [4] **The evidence for extending mental health screening across multiple prenatal and postpartum touchpoints is compelling.** A study in the Journal of Affective Disorders found that repeated PHQ-9 administration at 4-week intervals—beginning in the third trimester and continuing through 12 weeks postpartum—identified 34% more cases of depression than a single postpartum screen. [5]

Critically, mental health screening conducted virtually removes a significant participation barrier. **Mothers who would not disclose depressive symptoms in a clinic waiting room—or who would not attend at all—are more likely to engage with a brief validated questionnaire delivered through a text message, app, or telehealth platform in the privacy of their own home.** The channel is not incidental. For a population experiencing shame, exhaustion, and ambivalence about their own needs, the setting in which screening occurs materially affects whether it happens at all.

For health plans, this has direct quality implications. HEDIS measures for depression screening and follow-up are increasingly linked to maternal health composite scores. **Plans that implement multi-touch mental health screening—spanning pregnancy through the postpartum period—are better positioned to identify and intervene before a member's condition escalates to a level requiring emergency or inpatient care.** [15]

Proactive Appointment Scheduling with Multi-Channel Reminders

Our survey found that mothers who received both proactive appointment help and reminders attended at significantly higher rates. **The 193 respondents who identified reminders as the intervention most likely to have helped them attend represent the clearest, lowest-friction lever available to health plans.** Scheduling postpartum visits before hospital discharge can substantially improve postpartum follow-up attendance. One study found that postpartum visit attendance reached 94% among women whose appointments were scheduled before discharge, compared with 69.7% among historical controls.

The channel matters. For Medicaid populations, SMS-based outreach and peer navigator contact outperform letter-based reminders by a significant margin. For commercially insured members, app-based scheduling and email reminders are more effective. Neither population responds well to a single touchpoint. **Multi-channel, sequential outreach—beginning in the third trimester and continuing through the first six weeks postpartum—reflects how behavior change actually works.**

Strategic Implications for Health Plans

The postpartum visit is a high-visibility quality measure with a direct line to HEDIS performance, star ratings, and maternal health outcomes. More importantly, it is a genuine health equity issue. Plans that treat it as a checkbox will continue to see the same gaps. Plans that redesign the care pathway, beginning earlier, delivering care virtually, and screening for social and mental health needs across the full perinatal period, will see meaningfully different results.

For Commercial Plans

- Audit network adequacy specifically for postpartum OB/GYN providers in high-density member zip codes
- Implement proactive postpartum visit scheduling prior to hospital discharge through health system partnerships
- Cover and actively promote virtual postpartum visits as a standard benefit, with member-facing education on the option
- Deploy prenatal social needs screening with referral pathways to transportation, childcare, and food assistance
- Initiate mental health screening in the third trimester and repeat at 4-week intervals through 12 weeks postpartum
- Use multi-touch, digital-first outreach beginning in the third trimester to establish the postpartum care expectation early

For Medicaid Plans

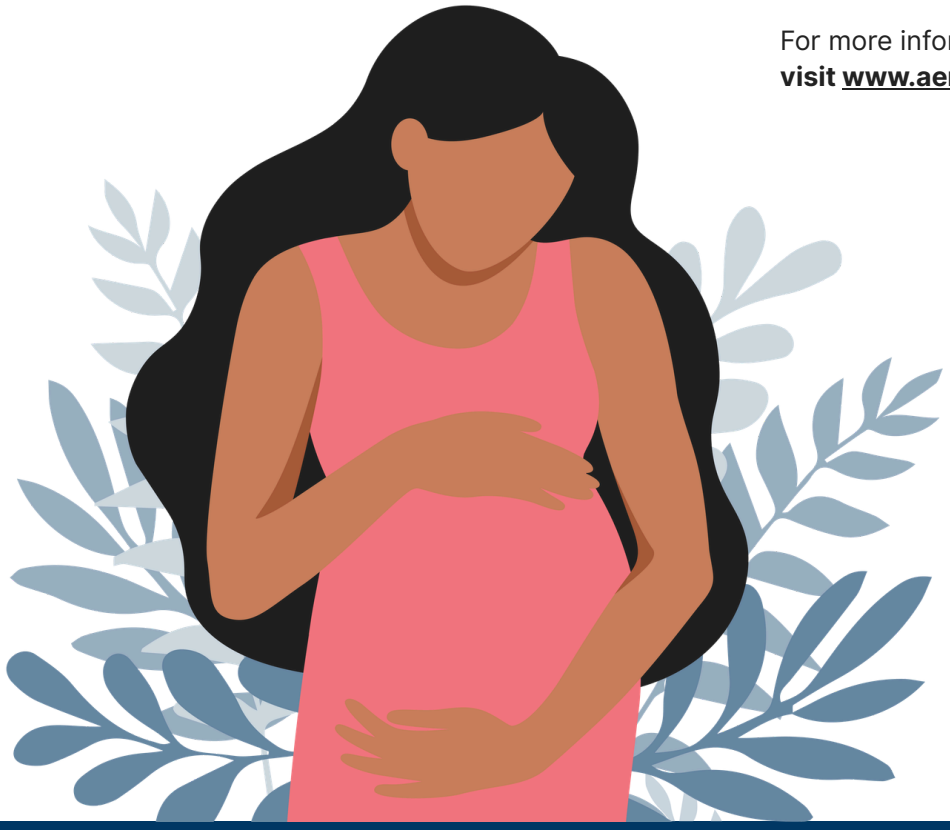
- Activate NEMT benefits proactively for all postpartum members with outbound confirmation of ride availability
- Invest in virtual and home-based postpartum visit programs as the primary care modality, not a fallback option
- Integrate social needs screening into care management workflows at multiple prenatal touchpoints, with warm handoffs to community resources
- Implement repeated, validated mental health screening (EPDS or PHQ-9) beginning in the third trimester through 12 weeks postpartum
- Use SMS-based scheduling, peer navigators, and community health workers rather than letter-based reminders
- Partner with clinic systems on infant-friendly scheduling policies to reduce the childcare barrier for in-person visits

Conclusion

When a new mother misses her postpartum visit, it is rarely because she does not care about her health. It is because the healthcare system—by design or by inertia—has not been built around the realities of her life.

The evidence is clear on what works. Proactive scheduling. Virtual care delivery. Social needs screening that starts during pregnancy. Mental health assessment that does not wait for the six-week visit to surface. Multi-channel reminders. Culturally responsive outreach. None of these are experimental—they are proven interventions with a strong evidence base and, relative to the cost of unaddressed maternal morbidity, an extraordinarily favorable return on investment.

Health plans that close the postpartum care gap—by starting earlier, reaching further, and delivering care in the formats that actually work for new mothers—will not only improve HEDIS scores, they will prevent maternal deaths, reduce the long-term burden of untreated postpartum depression, and demonstrate the kind of population health leadership that defines the most effective plans in the country.



The postpartum visit is not just a quality measure. It is a window. And for many mothers, the decision about whether that window stays open is made weeks before the appointment is ever scheduled.

About Aeroflow Health

Aeroflow Health partners with healthcare providers, payers and communities to improve access to healthcare and empower patients to improve their quality of life.

By offering innovative solutions and medical supplies—including Aeroflow Breastpumps, Aeroflow Urology, Aeroflow Sleep and Aeroflow Diabetes—Aeroflow ensures that patients can receive the care they need, when they need it most.

For more information,
visit www.aeroflowhealth.com.

References

All citations are numbered in the text as superscripts. Full references are listed below for fact-checking and further reading. URLs were verified as of publication date.

1. American College of Obstetricians and Gynecologists. (2018). ACOG Committee Opinion No. 736:Optimizing postpartum care. Obstetrics & Gynecology, 131(5), e140–e150. https://doi.org/10.1097/AOG.0000000000002633

2. American College of Obstetricians and Gynecologists. (2024, November). Addressing social and structural determinants of health in the delivery of reproductive health care (Committee Statement). ACOG. https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2024/11/addressing-social-and-structural-determinants-of-health-in-the-delivery-of-reproductive-health-care

3. American College of Obstetricians and Gynecologists. (n.d.). Implementing perinatal mental health screening. ACOG. https://www.acog.org/programs/perinatal-mental-health/implementing-perinatal-mental-health-screening

4. American Medical Women's Association. (2025). Maternal mental health disparities: The unseen struggle of postpartum depression. AMWA. https://amwa-doc.org/maternal-mental-health-disparities-the-unseen-struggle-of-postpartum-depression/

5. Aydin, B., & Çetin, B. A. (2026). Prevalence, predictors, and functional impact of postpartum depression using the Patient Health Questionnaire-9 (PHQ-9)among 830 women. BMC Pregnancy and Childbirth, 26, Article 137. https://doi.org/10.1186/s12884-026-08636-x

6. Cedar Gate Technologies. (2025, July 29). Cedar Gate data finds nearly 60% of new mothers miss essential postpartum follow-up care. GlobeNewswire. https://www.globenewswire.com/news-release/2025/07/29/3123232/0/en/cedar-gate-data-finds-nearly-60-of-new-mothers-miss-essential-postpartum-follow-up-care.html

7. Cleveland Clinic. (2026, March 26). Postpartum depression (PPD):Causes, symptoms & treatment. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/9312-postpartum-depression

8. Florida Blue. (2026, May 6). Florida Blue expands maternal health and well-being support for high-risk members. Florida Blue Newsroom. https://www.floridablue.com/newsroom/florida-blue-expands-maternal-health-and-well-being-support-for-high-risk-members

9. Healthgrades. (2024, September 17). OB-GYN appointment wait times vary in 15 metro markets. Healthgrades for Professionals. https://resources.healthgrades.com/pro/ob-gyn-appointment-wait-times-vary-in-15-metro-markets

10. Hirshberg, A., Downes, K., & Srinivas, S. (2018). Comparing standard office-based follow-up with text-based remote monitoring in the management of postpartum hypertension: A randomised clinical trial. BMJ Quality & Safety, 27(11), 871–877. https://doi.org/10.1136/bmjqs-2018-007837

11. Howard, L. M., & Khalifeh, H. (2020). Perinatal mental health: A review of progress and challenges. World Psychiatry, 19(3), 313–327. https://doi.org/10.1002/wps.20769

12. Kieffer, K. M., Fenton, A., Hobbs, A. J., O'Brien, L. M., Cote, A. M., & Rosenbloom, J. I. (2025). Characterizing intersecting social determinants of health during pregnancy: A descriptive cross-sectional analysis from a northern New England health system. Frontiers in Medicine, 12, Article 1658735. https://doi.org/10.3389/fmed.2025.1658735

13. Levine, J. A., Wickstrom, E., Perry, M., Chao, C. R., & Chuang, C. H. (2022). Addressing childcare as a barrier to healthcare access through community partnerships in a large public health system. BMJ Open Quality, 11(4), e001967. https://doi.org/10.1136/bmjoq-2022-001967

14. National Academy for State Health Policy. (2021, May 26). Addressing social determinants of health for pregnant and postpartum Medicaid beneficiaries. https://nashp.org/addressing-social-determinants-of-health-for-pregnant-and-postpartum-medicaid-beneficiaries/

15. National Committee for Quality Assurance. (2022, October 27). Postpartum depression screening and follow-up. State of Health Care Quality Report. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/postpartum-depression-screening-and-follow-up/

16. Petersen, E. E., et al. (2020). Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morbidity and Mortality Weekly Report, 68(35), 762–765. https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm

17. Razon, N., Gottlieb, L. M., & Fraze, T. (2023). Essential not supplemental: Medicare Advantage members' use of non-emergency medical transportation (NEMT). Journal of General Internal Medicine, 38(16), 3566–3573. https://doi.org/10.1007/s11606-023-08321-1

18. Verbiest, S., Bonzon, E., & Handler, A. (2016). Postpartum health and wellness: A call for quality woman-centered care. Maternal and Child Health Journal, 20(Suppl. 1), 1–7. https://doi.org/10.1007/s10995-016-2188-5

Additional References

1. Marko KI, et al. "Remotely Monitoring Patients During Pregnancy and the Postpartum Period with a Smartphone-Based System." J Med Internet Res, 2021; 23(3):e23125. https://www.jmir.org/2021/3/e23125

About This Research

This brief draws on a primary survey of 511 postpartum mothers conducted in November 2025. Respondents were stratified across insurance type (employer-sponsored, Medicaid, ACA/marketplace, TRICARE, and uninsured), age group (18–29 and 30–44), geography (all major U.S. Census regions), and household income.

Survey findings were contextualized using peer-reviewed research, clinical guidance, and national reports focused on postpartum care utilization, maternal mental health, health equity, and social determinants of health. Sources included the American College of Obstetricians and Gynecologists (ACOG), the Centers for Disease Control and Prevention (CDC), the National Committee for Quality Assurance (NCQA), the National Academy for State Health Policy (NASHP), Cleveland Clinic, and research published in Frontiers in Medicine, BMJ Open Quality, BMJ Quality & Safety, World Psychiatry, Maternal and Child Health Journal, Journal of General Internal Medicine, and BMC Pregnancy and Childbirth.

The research examines barriers that influence postpartum care engagement—including appointment availability, childcare needs, transportation challenges, mental health concerns, and social determinants of health—and explores opportunities to improve access, continuity of care, and maternal outcomes during the postpartum period. Full citations and source URLs are available in the References section.

Interested in partnering with Aeroflow Health on a research initiative or case study?
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