Missed and Delayed Preventive Health Care Visits Among US Children Due to the COVID-19 Pandemic

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Abstract

Objective: The COVID-19 pandemic led to a substantial drop in US children’s preventive care, which had not fully rebounded by the end of 2020. We sought to estimate the overall prevalence of missed, skipped, or delayed preventive checkups among households with children in the last 12 months because of the pandemic.

Methods: We used data from the US Census Bureau’s Household Pulse Survey, Phase 3.1 (collected April–May 2021). The analytic sample included 48,824 households with ≥1 child or adolescent aged <18 years. We estimated both national and state-level prevalences, examined associations with sociodemographic and household characteristics, and described reasons for missed or delayed preventive visits.

Results: Overall, 26.4% (95% CI, 25.5%-27.2%) of households reported that ≥1 child or adolescent had missed or delayed a preventive visit because of COVID-19; percentages varied by state, from 17.9% in Wyoming to 37.0% in Vermont. The prevalence of missed or delayed preventive visits was significantly higher among respondents who reported material hardships (ie, not caught up on rent/mortgage, difficulty paying usual household expenses, children not eating enough because of lack of affordability) than among respondents who did not report material hardships. The most common reasons for missing or delaying preventive visits were concern about visiting a health care provider, limited appointment availability, and the provider’s location being closed.

Conclusions: Programs and policies could reduce gaps in children’s preventive care caused by the pandemic, with a particular focus on addressing social determinants of health.

Keywords
children, preventive health care, pediatric care, forgone care, unmet health care, COVID-19

The direct impacts of the COVID-19 pandemic on children in the United States have been relatively small, yet substantial, compared with the impacts on adults. The Centers for Disease Control and Prevention (CDC) estimated that as of May 2021, 23 million children and adolescents aged 0-17 years had had symptomatic COVID-19, with >200,000 hospitalizations and approximately 330 deaths.1 Since the Delta variant has become dominant in the United States, the number of cases of COVID-19 among children has increased, and although disease severity has not worsened, pediatric hospitalizations have increased as a result of higher overall case numbers.2,3 The indirect impacts of the pandemic on children’s health and well-being have been even more widespread, including parental job loss, family financial struggles, childcare and school closures, extended social isolation, and bereavement.4-7

Preventive health care for children is critical for addressing the physical, mental, and emotional sequelae of the pandemic’s effects and for providing routine vaccinations, tracking developmental milestones, intervening early on identified health concerns, and providing support to families. The onset of the pandemic brought a sudden and substantial drop in children’s preventive care. From March through July 2020, children insured by Medicaid and the Children’s Health Insurance Program (CHIP) received 12% fewer routine vaccinations (among beneficiaries aged ≤2 years), 29% fewer screening services, and 35% fewer outpatient mental health services.8 Non-influenza and measles-containing vaccine orders for the Vaccines for Children program substantially decreased after the COVID-19 pandemic.
national emergency was declared, especially among children and adolescents aged ≥2 years. As of September 2020, 13% of parents reported delaying or forgoing their children’s checkups, well-child visits, and other preventive health screenings. Although children’s outpatient visits rebounded by the end of 2020, visit volumes had not returned to pre-pandemic levels, resulting in a 27% cumulative decrease in pediatric visits. Among children aged ≤5 years, missed visits were more common among lower-income, Black, and Latinx households than among higher-income and White households.

In this study, we analyzed data collected during April–May 2021 from a nationally representative survey to estimate the prevalence and associated covariates of missed or delayed preventive visits among households with children and adolescents aged 0-17 years because of the COVID-19 pandemic. We hypothesized that populations who have historically had poorer access to and use of health care would more frequently report missed or delayed preventive care for children than populations with greater access to and use of health care.

Methods

We used data from the US Census Bureau’s Household Pulse Survey (HPS), initially launched in April 2020 to measure US household experiences during the COVID-19 pandemic. The online survey is administered in English and Spanish and is conducted on a rolling basis, with data publicly released every 2 weeks to provide near–real-time information. Households are randomly sampled using the Census Bureau’s Master Address File, and potential respondents are invited by text and/or email to participate in an internet survey. We analyzed data collected from April 14 through May 10, 2021 (weeks 28 and 29), from Phase 3.1 of the HPS. A total of 2,081,251 households were invited to participate, and 147,380 respondents completed the survey, including 48,824 households with children and adolescents aged <18 years. Weekly response rates (proportion of invited households that completed the survey during each 2-week data collection period) ranged from 6.6% to 7.5%.

Respondents were asked, “At any time in the last 12 months, did any children in the household miss, delay, or skip any preventive checkups because of the coronavirus pandemic?” We estimated the proportion of households that reported any missed or delayed pediatric preventive visits, both nationally and by state; calculated chi-squared statistics (Pearson χ² test of independence for categorical variables) to test for significant bivariate (crude) associations between missed or delayed preventive visits and sociodemographic and household characteristics; and described reasons for children’s missed or delayed preventive visits. All analyses used a significance level of .05. Estimates were weighted for nonresponse and to match the Census Bureau’s estimates of the US population by age, sex, race, Hispanic ethnicity, and education level. We conducted analyses in SAS version 9.4 (SAS Institute, Inc) using survey procedures and incorporating 80 replicate weights with Fay’s adjustment to account for the complex survey design. Because we analyzed secondary, publicly available data, institutional review board review and approval were deemed not necessary in accordance with the US Department of Health and Human Services regulations for the protection of human subjects in research (45 CFR 46).

Results

Overall, 26.4% (95% CI, 25.5%-27.2%) of US households with children reported that ≥1 child or adolescent had missed, skipped, or delayed preventive checkups in the last 12 months because of COVID-19 (Table 1). We found wide variation in missed or delayed preventive visits by state of residence, from 17.9% (95% CI, 11.7%-24.2%) in Wyoming to 37.0% (95% CI, 27.6%-46.4%) in Vermont. In addition, the prevalence of missed or delayed preventive visits differed significantly by US Census region, ranging from 24.9% (95% CI, 23.0%-26.8%) in the Northeast to 28.5% (95% CI, 26.8%-30.2%) in the West.

We found significant differences by respondent race and ethnicity, education, and marital status (Table 2). Children’s missed or delayed preventive visits were more frequently reported by respondents who identified as non-Hispanic other/multirace (31.6%; 95% CI, 27.9%-35.3%), had ≥bachelor’s degree (29.4%; 95% CI, 28.7%-30.2%), and were married (27.6%; 95% CI, 26.6%-28.6%) and least frequently reported by respondents who identified as non-Hispanic Black (24.3%; 95% CI, 22.1%-26.5%), had ≤high school degree/general education development (22.4%; 95% CI, 20.3%-24.5%), and were not married (24.3%; 95% CI, 22.6%-26.0%). In addition, households with 3 to 5 children more frequently reported missed or delayed preventive visits (33.4%; 95% CI, 31.5%-35.3%) than households with fewer children (1 child: 20.7% [95% CI, 19.2%-22.2%]; 2 children: 29.8% [95% CI, 28.5%-31.2%]).

The prevalence of missed or delayed preventive visits was similar across household federal poverty levels (P = .63). However, missed or delayed preventive visits were significantly higher among respondents who were not caught up on rent/mortgage (30.6%; 95% CI, 27.8%-33.4%) than among respondents who were caught up on rent/mortgage (26.0%; 95% CI, 25.1%-26.9%; P < .001); among respondents who had difficulty paying usual household expenses in the last 7 days (31.8%; 95% CI, 29.8%-33.8%) than among respondents with little or no difficulty paying expenses (23.9%; 95% CI, 23.0%-24.8%; P < .001); and among respondents who reported children were not eating enough in the last 7 days because of lack of affordability (37.6%; 95% CI, 33.2%-41.9%) than among respondents whose children never lacked in food (25.0%; 95% CI, 24.3%-25.7%; P < .001). We found no significant differences in missed or delayed preventive
Table 1. Households with any children aged <18 years who missed, skipped, or delayed a preventive checkup in the last 12 months, by region and statea

| Household location | No.   | Missed or delayed preventive visit because of COVID-19 pandemic |
|--------------------|-------|---------------------------------------------------------------|
|                    |       | % (95% CI)b                                                  |
| United States      | 10 742 | 26.4 (25.5-27.2)                                            |
| Regionc            |       |                                                              |
| Northeast          | 1631  | 24.9 (23.0-26.8)                                            |
| South              | 3226  | 25.9 (24.5-27.2)                                            |
| Midwest            | 2162  | 26.1 (24.5-27.7)                                            |
| West               | 3723  | 28.5 (26.8-30.2)                                            |
| State              |       |                                                              |
| Alabama            | 124   | 26.1 (20.3-32.0)                                            |
| Alaska             | 271   | 30.8 (25.9-35.7)                                            |
| Arizona            | 273   | 28.9 (24.7-33.2)                                            |
| Arkansas           | 114   | 25.6 (18.5-32.6)                                            |
| California         | 1011  | 29.9 (26.9-32.9)                                            |
| Connecticut        | 258   | 25.9 (22.2-29.7)                                            |
| Colorado           | 175   | 28.2 (23.8-32.6)                                            |
| Delaware           | 112   | 24.3 (19.4-29.2)                                            |
| District of Columbia| 118   | 25.5 (17.7-33.2)                                            |
| Florida            | 276   | 21.8 (16.7-26.9)                                            |
| Georgia            | 225   | 26.8 (20.8-32.7)                                            |
| Hawaii             | 111   | 25.1 (19.4-30.9)                                            |
| Idaho              | 197   | 27.4 (22.3-32.4)                                            |
| Illinois           | 272   | 23.7 (20.7-26.7)                                            |
| Indiana            | 198   | 24.9 (19.6-30.1)                                            |
| Iowa               | 120   | 21.2 (16.4-26.0)                                            |
| Kansas             | 155   | 27.1 (22.4-31.8)                                            |
| Kentucky           | 114   | 25.7 (21.0-30.3)                                            |
| Louisiana          | 116   | 24.2 (18.4-29.9)                                            |
| Maine              | 101   | 28.6 (22.2-35.0)                                            |
| Maryland           | 306   | 23.8 (20.1-27.6)                                            |
| Massachusetts      | 294   | 24.3 (21.2-27.5)                                            |
| Michigan           | 316   | 27.6 (22.9-32.2)                                            |
| Minnesota          | 298   | 27.5 (24.3-30.7)                                            |
| Mississippi        | 64    | 24.6 (18.6-30.6)                                            |
| Missouri           | 157   | 26.1 (21.8-30.4)                                            |
| Montana            | 85    | 23.6 (17.0-30.2)                                            |
| Nebraska           | 133   | 23.2 (18.8-27.5)                                            |
| Nevada             | 164   | 29.4 (23.2-35.6)                                            |
| New Hampshire      | 159   | 22.5 (17.9-27.0)                                            |
| New Jersey         | 242   | 28.4 (23.0-33.8)                                            |
| New Mexico         | 213   | 24.2 (20.2-28.1)                                            |
| New York           | 205   | 23.4 (19.1-27.8)                                            |
| North Carolina     | 187   | 25.4 (20.3-30.5)                                            |
| North Dakota       | 70    | 21.5 (15.9-27.2)                                            |
| Ohio               | 179   | 29.6 (23.8-35.4)                                            |
| Oklahoma           | 132   | 24.4 (19.4-29.5)                                            |
| Oregon             | 305   | 28.6 (24.9-32.2)                                            |
| Pennsylvania       | 294   | 26.0 (21.9-30.0)                                            |
| Rhode Island       | 83    | 24.3 (18.2-30.4)                                            |
| South Carolina     | 101   | 25.2 (17.3-33.1)                                            |
| South Dakota       | 72    | 22.3 (15.7-29.0)                                            |

(continued)
visits by respondent health insurance or respondent/spouse military status.

The most common reasons given for missed or delayed preventive visits because of COVID-19 were limited appointments available at the health care provider’s location (42.7%), concern about going to the health care provider’s location (41.9%), and the health care provider’s location being closed (28.6%). Furthermore, some respondents reported preventive care was missed or delayed because someone in the household was exposed to the coronavirus (8.6%), someone in the household was ill with coronavirus (7.1%), and the child had a loss or change in health insurance (4.4%).

Discussion

In this study, 1 in 4 US households reported that ≥1 child missed, skipped, or delayed preventive visits in the past year because of COVID-19. Notably, households experiencing various material hardships—housing difficulties, food insufficiency, and difficulty paying expenses—were more likely to report missed or delayed preventive visits than those who did not experience material hardships. These findings confirm earlier studies that showed many US children and adolescents have missed critical primary and preventive care because of the pandemic.\(^5,6,8\) Targeted efforts are needed to help families catch up on children’s preventive visits, particularly among children who have been economically impacted by COVID-19. Even before the pandemic, US children on average received only 59% of recommended well-child visits.\(^14\) Although caregivers understand the value of these visits, transportation difficulties, challenges associated with taking time off work, childcare issues, and other social stressors are barriers to attending well-child visits.\(^15\)

The pandemic has exacerbated these barriers and created new ones, highlighting the need to address social determinants of health to increase children’s receipt of primary and preventive visits. We also found that the prevalence of children’s missed or delayed preventive visits increased with higher adult education levels and was slightly higher among households with married respondents than among households with unmarried respondents. These findings contrast with patterns of preventive care use and unmet health care needs typically seen before the pandemic.\(^16-19\) Although the absolute difference between estimates may be small in some cases (with the large sample size likely contributing to significance), it is noteworthy from a clinical and population health standpoint that up to one-third of children in certain subpopulations of interest missed or delayed important preventive care during the pandemic.

Study findings can inform programs and policies to address gaps in children’s preventive visits caused by the COVID-19 pandemic. To the extent that missed or delayed preventive visits were caused by hardships, opportunities may exist for promotion of and referrals to primary care when families access other services aimed at addressing those hardships, such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).\(^20\) Colocation or coordination of services (eg, WIC and primary care) may further facilitate access to well-child visits and immunizations.\(^21\)

The survey findings also draw attention to the linkage between social determinants of health (eg, economic stability, food security) and health-related outcomes. Although policy approaches to address these social determinants (such as provisions in the American Rescue Plan to increase WIC participation) on the surface do not appear to be “health care” solutions, they may in fact alleviate hardships and increase the likelihood of receiving preventive care.\(^22\)

Patterns of care may also have changed during the pandemic. The survey asked about experiences during the past 12 months; however, reports of missed or delayed preventive visits do not necessarily mean that children were still deficient in their receipt of care at the time of survey completion.

### Table 1. (continued)

| Household location | No. | % (95% CI)b |
|--------------------|-----|-------------|
| Tennessee          | 164 | 26.2 (21.9-30.4) |
| Texas              | 608 | 28.6 (25.1-32.0) |
| Utah               | 301 | 22.7 (19.6-25.8) |
| Vermont            | 107 | 37.0 (27.6-46.4) |
| Virginia           | 354 | 29.3 (25.4-33.1) |
| Washington         | 445 | 28.3 (25.1-31.4) |
| West Virginia      | 111 | 29.9 (21.6-38.2) |
| Wisconsin          | 192 | 26.4 (22.0-30.9) |
| Wyoming            | 60  | 17.9 (11.7-24.2) |

\(^a\)Data source: US Census Household Pulse Survey Phase 3.1, April 14–May 10, 2021.\(^13\)

\(^b\)Observations are unweighted; percentages are weighted.

\(^c\)Significant at \(P = .02\) using Pearson \(\chi^2\) test of independence.
### Table 2. Characteristics of households with children aged <18 years and prevalence of households with children who missed, skipped, or delayed a preventive checkup in the last 12 months, overall and by sociodemographic and household characteristics, April 14–May 10, 2021a

| Characteristic                                      | Households with children | Missed or delayed preventive visit because of COVID-19 pandemic | P valuec |
|-----------------------------------------------------|--------------------------|-----------------------------------------------------------------|----------|
|                                                      | No. | % (95% CI)b              | No. | % (95% CI)b              |
| Overall                                             | 48 824 | 100.0                   | 10 742 | 26.4 (25.5-27.2) |
| Characteristics of adult respondentsd               |     |                        |     |                       |
| Race and ethnicity                                   |     |                        |     |                       |
| Non-Hispanic Asian/Pacific Islander                 | 33 18 | 6.0 (5.6-6.4)            | 697 | 29.3 (24.4-34.2) |
| Non-Hispanic Black                                  | 44 39 | 14.7 (14.2-15.3)         | 799 | 24.3 (22.1-26.5) |
| Hispanic                                            | 63 50 | 20.6 (19.9-21.3)         | 1292 | 26.6 (24.2-28.9) |
| Non-Hispanic White                                  | 32 648 | 54.7 (54.0-55.4)         | 7443 | 26.1 (25.3-27.0) |
| Non-Hispanic other/multirace                        | 20 69 | 4.0 (3.7-4.2)            | 512 | 31.6 (27.9-35.3) |
| Education                                           |     |                        |     |                       |
| ≤ High school degree/GED                            | 70 04 | 40.2 (39.5-40.9)         | 1032 | 22.4 (20.3-24.5) |
| Some college/associate’s degree                     | 14 846 | 29.2 (28.6-29.8)         | 3136 | 27.7 (26.5-28.8) |
| ≥ Bachelor’s degree                                 | 26 974 | 30.6 (30.1-31.1)         | 6574 | 29.4 (28.7-30.2) |
| Marital status                                      |     |                        |     |                       |
| Married                                             | 33 844 | 60.7 (59.8-61.6)         | 7848 | 27.6 (26.6-28.6) |
| Not married                                         | 14 690* | 39.3 (38.4-40.2)        | 2859* | 24.3 (22.6-26.0) |
| Health insurance                                    |     |                        |     |                       |
| Private                                             | 26 576 | 58.2 (57.2-59.2)         | 7729 | 26.9 (26.0-27.7) |
| Any public                                          | 9254 | 29.4 (28.4-30.3)         | 2379 | 26.6 (24.7-28.4) |
| None                                                | 24 265* | 11.3 (10.6-12.1)        | 558* | 32.3 (20.3-26.2) |
| Serving in US Armed Forces or National Guard        |     |                        |     |                       |
| Yes                                                 | 965 | 1.7 (1.5-1.9)             | 252 | 30.9 (25.0-36.9) |
| No                                                  | 47 553* | 98.3 (98.1-98.5)        | 10 452* | 26.3 (25.4-27.2) |
| Household characteristics                            |     |                        |     |                       |
| No. of children                                     |     |                        |     |                       |
| 1                                                   | 22 424 | 45.6 (44.8-46.5)         | 3920 | 20.7 (19.2-22.2) |
| 2                                                   | 17 187 | 33.6 (32.8-34.3)         | 4254 | 29.8 (28.5-31.2) |
| 3-5                                                | 9213* | 20.8 (20.2-21.5)         | 2568 | 33.4 (31.5-35.3) |
| % Federal poverty levelf                            |     |                        |     |                       |
| ≤138%                                               | 48 46 | 24.2 (23.4-24.9)         | 1357 | 26.0 (23.7-28.3) |
| >139%-200%                                          | 3872 | 15.4 (14.6-16.2)         | 1091 | 27.8 (25.4-30.2) |
| >201%-400%                                          | 8590 | 25.3 (24.5-26.2)         | 2543 | 27.5 (25.4-29.7) |
| >400%                                               | 16 787* | 35.1 (34.2-36.0)        | 4892* | 27.0 (26.0-27.9) |
| Caught up on rent/mortgage                           |     |                        |     |                       |
| Yes                                                 | 33 224 | 87.9 (86.9-89.0)        | 9342 | 26.0 (25.1-26.9) |
| No                                                  | 3190* | 12.1 (11.0-13.1)         | 1101* | 30.6 (27.8-33.4) |
| Difficulty paying usual household expenses, last 7 days |     |                        |     |                       |
| Not at all/a little difficult                       | 34 913 | 67.1 (65.9-68.3)         | 7765 | 23.9 (23.0-24.8) |
| Very/somewhat difficult                             | 10 985* | 32.9 (31.7-34.1)        | 2970* | 31.8 (29.8-33.8) |
| Children not eating enough because of lack of affordability, last 7 days |     |                        |     |                       |
| Never true                                          | 38 788 | 88.3 (87.2-89.3)        | 9649 | 25.0 (24.3-25.7) |
| Often/sometimes true                                | 3006* | 11.7 (10.7-12.8)         | 1074* | 37.6 (33.2-41.9) |
| No. of hardshipsf                                   |     |                        |     |                       |
| 0                                                   | 33 349 | 62.9 (61.6-64.1)         | 7322 | 23.5 (22.7-24.3) |
| 1                                                   | 8692 | 24.4 (23.2-25.6)         | 2037 | 28.8 (26.9-30.7) |
| 2 or 3                                              | 3809* | 12.7 (11.7-13.8)         | 1383 | 35.1 (31.9-38.2) |

Abbreviation: GED, general education development.

a Data source: US Census Household Pulse Survey Phase 3.1, April 14–May 10, 2021.13
b Observations are unweighted; percentages are weighted.
c Significant at P < .05 using the Pearson χ² test of independence.
d Data on sociodemographic characteristics were only collected for the adult respondent, not for the children in the household.

* Total observations do not add up to overall total because of missing data (respondent did not answer the relevant survey item[s]). Percentages are calculated based on nonmissing data.
+ Calculated using reported 2019 household income.
+ Sum of the 3 hardships (caught up on rent/mortgage, difficulty paying usual household expenses, children not eating enough).
Among reasons for missing or delaying preventive visits, respondents reported being unable to get an appointment, not wanting to go to the clinic, or the clinic being closed. Some of these factors may have been more prevalent closer to the start of the pandemic, when ambulatory care settings were limiting appointments, but practice patterns have changed during the pandemic.\(^\text{23-24}\) Regardless of why families did not seek care, some deficits have persisted. CDC noted a 20% decline in measles-containing vaccine orders for 2020-2021 compared with 2019.\(^\text{25}\) State immunization programs and clinics can use reminder-recall systems to alert families whose children may be behind on vaccines.\(^\text{26,27}\) In a similar manner, practices may need to conduct proactive outreach to encourage families to come in for preventive visits if families are unaware of changes in health care practice patterns and availability of services. Given that 4 in 10 households with missed or delayed preventive visits reported concerns about safety at the provider’s location, such outreach may be an important opportunity to inform and reassure parents about steps the provider is taking to keep them and their children safe. Providers may also explore alternate hours (nights/weekends) to improve access, which can address a need that is not unique to the pandemic.\(^\text{28,29}\)

Finally, these findings point to important considerations for future emergency planning that incorporate the unique needs of children and adolescents. Delays in well-child visits and immunizations put children at increased risk for infectious disease and missed identification of developmental delays.\(^\text{30,31}\) Well-child visits also provide opportunities to identify mental and behavioral health concerns.\(^\text{32}\) During the pandemic, the proportion of pediatric emergency department visits for mental/behavioral concerns increased, indicating a need for services that may be addressed during a well-child visit.\(^\text{33,34}\) Furthermore, emergency preparedness plans should include alternative care delivery modalities for primary care, such as telehealth, hybrid models, or outdoor or drive-through clinics for administration of routine vaccinations.\(^\text{35-37}\) In addition, health insurance plans will need to quickly pivot to support alternative delivery approaches to ensure continuity of care, as did Medicaid and CHIP programs to expand telehealth during the COVID-19 pandemic.\(^\text{38}\) The pediatric population is not monolithic and needs may vary across age groups. For example, the design and delivery of telehealth services for adolescents may require special considerations compared with other age groups.\(^\text{39}\)

**Limitations**

This study had several limitations. First, survey respondents might not be the parents/caregivers of the children living in the household, and some respondents might have been unfamiliar with children’s health care use (or lack thereof), potentially leading to inaccurate survey responses. Second, respondents reported their own health insurance type and race and ethnicity, which might not match the health insurance type and race and ethnicity of children in the household. Therefore, caution is advised in interpreting measures of association between these covariates and missed or delayed preventive visits. Third, the HPS collected sociodemographic information about adult respondents but not about the children in the household; therefore, we were unable to examine differences by child age. Fourth, the HPS is a rapidly implemented experimental data system that relies on online response, increasing susceptibility to nonsampling errors. Specifically, the online survey administration may have posed a barrier to populations with limited access to the internet. However, as of 2021, 96% to 99% of adults aged 18-64 years nationwide reported using the internet.\(^\text{40}\) Certain populations, such as low-income households or rural households, have seen sharp increases in smartphone use during the past decade, which enables the completion of web-based tasks, although a digital divide persists.\(^\text{40,41}\) Finally, nonresponse bias analyses conducted by the US Census Bureau showed evidence that response patterns differed across demographic domains, which may have led to biased estimates; however, weighting adjustments should mitigate nonresponse bias.\(^\text{42}\)

**Conclusion**

One-quarter of households with children reported missing, skipping, or delaying preventive checkups because of the COVID-19 pandemic. Additional data are needed to identify those households that continue to lag in pediatric primary and preventive care even as the United States pursues recovery efforts. Material hardships were associated with an increased likelihood of missing or delaying children’s preventive visits, and the prevalence of missed or delayed visits increased as the number of hardships increased. Forgone preventive visits can result in missed opportunities to identify developmental delays, protect children against vaccine-preventable diseases, and connect families with health and social resources in the community. Efforts to reduce or eliminate hardships by addressing social determinants of health are needed, as are alternative approaches to care delivery, to ensure the timely receipt of routine pediatric preventive care.

**Disclaimer**

The views expressed in this article are those of the authors and do not necessarily reflect the official policies of the US Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA), nor does mention of HHS or HRSA imply endorsement by the US government.

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