Colorado Postpartum Care and Perinatal Mental Health Utilization Analysis (2019-2023)

Executive Summary

Executive Summary Prepared by the Colorado Perinatal Care Quality Collaborative (CPCQC):
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October 2025

Background

The weeks after birth are the highest-risk period for new parents, especially those with mental health conditions. In Colorado, over **80% of pregnancy-associated deaths occurred postpartum** (2017–2021), with nearly 60% occurring after 6 weeks (43 days) postpartum.[1] Suicide was the leading cause of pregnancy-associated death, and 100% of suicide deaths were deemed *preventable*.[2] The majority of pregnancy-related deaths from suicide occurred between six weeks and one year postpartum (58.3%, Colorado Department of Public Health and Environment (CDPHE), 2023).[3] These statistics underscore the importance of timely, coordinated postpartum care, particularly to address mental health conditions.

To better understand perinatal mental health needs and gaps in care, CPCQC partnered with the Center for Improving Value in Health Care (CIVHC) to analyze perinatal mental health diagnoses, perinatal mental healthcare utilization, and postpartum visit attendance using the Colorado All Payer Claims Database (2019–2023). The study examined care patterns for more than **170,000 deliveries**—roughly half of all births in Colorado—tracking postpartum visits and mental health diagnoses and utilization *during pregnancy and up to 12 months postpartum* (the "perinatal" period). This Executive Summary was developed independently by CPCQC, drawing on analyses conducted with data provided by CIVHC.

Note that this analysis was unable to analyze claims for substance use; only mental health claims were included. Readers seeking more detailed analyses and interpretations can refer to the full report, which provides expanded context on study population, methodological notes, and discussion of the findings.

Key findings and implications are highlighted below. For each topic, we examine the typical pattern from 2019-2023, as well as changes from 2019 to 2023. Click on any topic to navigate to that section.

[1] Pregnancy-associated deaths include all deaths that occur during pregnancy or within one year of the end of pregnancy, regardless of the cause of death. Pregnancy can end by live birth, stillbirth, fetal death, miscarriage, or abortion (CDPHE, 2023).

[2] Preventable means there was at least some chance of the death being averted by one or more reasonable changes at the patient, provider, facility, systems, or community levels (CDPHE, 2023).

[3] Pregnancy-related deaths comprise a subset of pregnancy-associated deaths, where the death is due to a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. In the case of a pregnancy-related death, the person would not have died had they not been pregnant.

Perinatal Mental Health

Perinatal mood and anxiety disorders are some of the most common complications of pregnancy, affecting around 20% of postpartum individuals (Policy Center for Maternal Mental Health, 2025) and contributing to 40% of pregnancy-related and pregnancy-associated deaths (CDPHE, 2023).

Key findings: Mental health diagnoses are common during the perinatal period. More than a third of deliveries in Colorado from 2019-2023 were to an individual with a mental health diagnosis, most commonly depression or anxiety. The proportion of perinatal individuals with a mental health diagnosis increased from 2019-2023.

- More than one-third of deliveries (36.7% of 173,545 total deliveries) in Colorado between 2019-2023 were to an individual with a mental health diagnosis, reflecting the broad prevalence of mental health conditions during the perinatal period (see Figure 1).
- Among deliveries to individuals with any mental health diagnosis, 93% were classified as *non-severe mental illnesses*, such as anxiety or depression, and 7% as *severe mental illnesses*, such as bipolar disorder, schizophrenia, or severe depressive disorder.[4]
- The percentage of deliveries to individuals diagnosed with *non-severe mental illness* increased significantly from 2019-2023, accounting for a decrease in deliveries to individuals with *no mental illness* diagnosis (see Figure 1). While our analysis cannot explain causes for increased diagnoses or treatment, our full report posits several possible contributors that may have played a role during this study period, including increased mental health stressors during COVID-19 and expansions in screening and diagnosis pathways via telehealth, postpartum Medicaid extension, and Colorado Medicaid behavioral health services. A forthcoming secondary analysis in partnership with CIVHC will explore telehealth utilization for mental healthcare during this study period.

[4] Labels follow ICD-10 conventions and are used for analytic categorization only, not to indicate severity or impact.

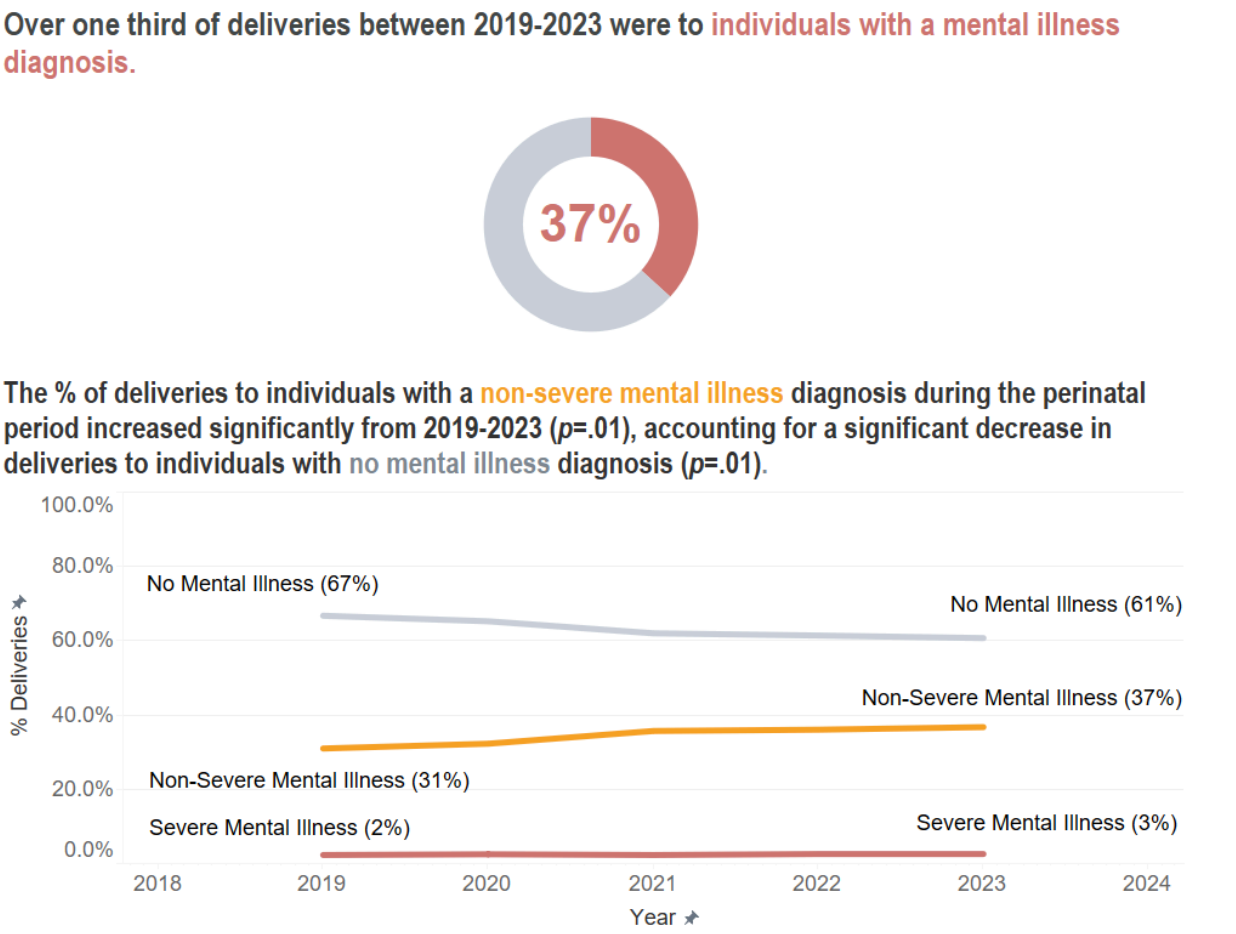

Figure 1. Prevalence of deliveries to individuals with a mental illness diagnosis, on average from 2019-2023 (top graph) and by year (bottom graph). The slopes for "no mental illness" and "non-severe mental illness" are statistically significant, with p-values of .01 each.

Implications: Mental healthcare needs are common in the perinatal period. Mental healthcare must remain a key priority to improve the wellbeing of perinatal individuals and reduce their risk for maternal mortality, particularly in the postpartum period.

Mental Healthcare Use

Accessing consistent and ongoing mental healthcare during the perinatal period provides the opportunity to treat the perinatal mood and anxiety disorders that contribute to maternal mortality and morbidity. Recommended treatment for common perinatal mental mood and anxiety disorders includes regular mental health therapy for 3-6 months, in addition to medication management as clinically indicated.

However, a recent study of a nationally representative sample found that among perinatal women with mental health disorders, over 60% do not receive mental health services. Furthermore, pregnant

and postpartum women are less likely than the general population to access mental healthcare (Pankratz, et al., 2024), with research showing that perceived cost, opposition to treatment, and stigma had significant negative impact on service utilization (Salameh et al., 2020).

To better understand these patterns in Colorado, this analysis examined how often patients with a documented mental health diagnosis used mental healthcare during pregnancy and up to one year postpartum, based on insurance claims showing both a mental health diagnosis and a corresponding service visit. [5]

Key findings: Overall use of mental healthcare in the perinatal period remains low, especially prenatally. In Colorado from 2019-2023, 80% of *prenatal* individuals with mental health diagnoses did not receive any mental health services, and 66% of *postpartum* individuals with mental health diagnoses did not receive any mental health services. However, the proportion of perinatal individuals with a mental health diagnosis who received mental healthcare increased from 2019-2023.

- Overall use of mental healthcare among those with a mental health diagnosis during the perinatal period remains low relative to recommended treatment, especially prenatally, and especially among the much larger group of individuals with a non-severe mental illness (see Figure 3).
- Individuals with a mental health diagnosis were more likely to have a mental health appointment during postpartum (34%) than during pregnancy (20%) (see Figure 3), potentially reflecting greater stressors experienced in the postpartum period relative to the prenatal period, and greater attention to postpartum mental health conditions among perinatal healthcare workers. However, this indicates that the vast majority of those with a mental health diagnosis do not receive any treatment during the vulnerable perinatal period.
- On average, individuals who received mental health services had *fewer than one appointment across the perinatal period*, far below the recommended course of treatment for mental health diagnoses. On average, just 8% of patients with a mental health diagnosis completed *5 or more mental health appointments* between 2019-2023. While this increased from 6.5% in 2019 to 10.2% in 2023, indicating more patients are engaging in clinical treatment for longer periods of time, it still reflects what is likely under-treatment.
- Across both prenatal and postpartum periods, and severity of diagnoses, mental healthcare appointment use increased from 2019 to 2023, suggesting greater access to and/or use of behavioral healthcare (Figure 3).

[5] Mental health (MH) claims were identified when a mental health diagnosis appeared as the *primary diagnosis* on the claim and the visit included one or more CPT or HCPCS codes for a mental health service. The data represent diagnoses occurring at any point during the perinatal period (42 weeks before through 12 months after delivery) and may therefore include both pre-existing and newly identified mental health conditions. Mental health service use among individuals *without* a documented mental health diagnosis is not included in this analysis.

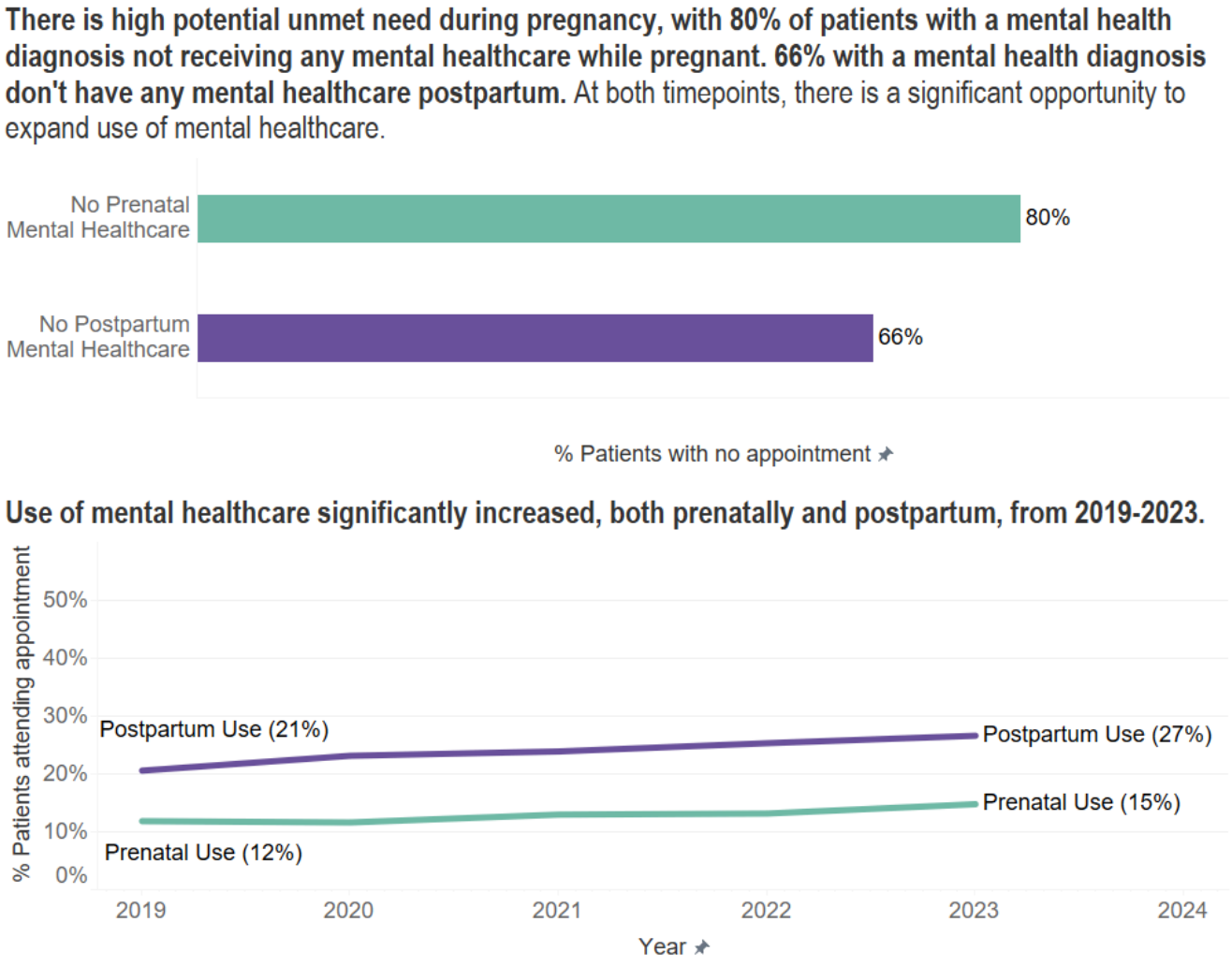

Figure 3. Perinatal behavioral health use on average (top chart), and by year and perinatal timing (prenatal vs. postpartum, bottom chart). The postpartum use slope increased significantly, p=.002, as did the prenatal use slope, p=.02.

Implications: The number of patients accessing mental healthcare is increasing. However, there remains a large opportunity to ensure that more patients with mental health diagnoses receive not only a first mental health appointment, but a meaningful course of treatment for their mental health condition.

Postpartum Visit Attendance

The postpartum period is one of particular vulnerabilities for both obstetric and mental health complications, underscoring the need for timely and comprehensive postpartum care. Between 2017 and 2021, 81.4% of all pregnancy-associated deaths in Colorado occurred within the first year postpartum; this 81.4% is comprised of about a quarter (24.5%) of pregnancy-associated deaths which occurred in the first 6 weeks (42 days), and over half (56.9%) which occurred after 6 weeks

postpartum. Nearly 60% (58.3%) of pregnancy-related deaths from suicide also occurred between six weeks and one year postpartum. These statistics highlight both the importance of earlier, comprehensive postpartum care and the need for continued mental health screening, patient education, and universal resource sharing beyond the traditional 6-12 week postpartum period to address mental health conditions that may emerge within the first year postpartum (CDPHE 2023).

In 2018, the American College of Obstetricians and Gynecologists (ACOG) issued guidance recommending that postpartum care shift from the convention of a single visit at six weeks to an ongoing, individualized process which includes initial contact within three weeks of birth and a comprehensive visit by 12 weeks, tailored to the patient's needs. Many obstetric providers have since adopted earlier follow-up—often through a two-week telehealth visit—in response to this guidance. The methodology used for this analysis cannot determine the exact timing of visits within the first six weeks or whether they occurred via telehealth; however, it examined postpartum visit attendance by six, eight, and twelve weeks.

Key findings: Nearly 3 in 10 (29%) of individuals in Colorado did not attend a postpartum appointment by 12 weeks. However, from 2019-2023, 6 week visits increased relative to 8 week visits, potentially reflecting broader adoption of best practice guidelines towards earlier postpartum care.

- While it is a positive sign that over 70% of individuals attended a postpartum visit within the first 12 weeks, a remaining nearly 30% of individuals did not attend a postpartum appointment by 12 weeks postpartum.
- Postpartum appointment attendance by 6 weeks increased from 2019 to 2023, while attendance by 8 weeks declined slightly, suggesting a shift from 8 week visits to 6 week visits (see Figure 2). The proportion who had no postpartum visits declined by about 4% (32% to 28%), but did not achieve statistical significance.

- This analysis could not tell us what proportion of patients attended an appointment between 12 weeks and 1 year, though a forthcoming, second phase of research may address this.

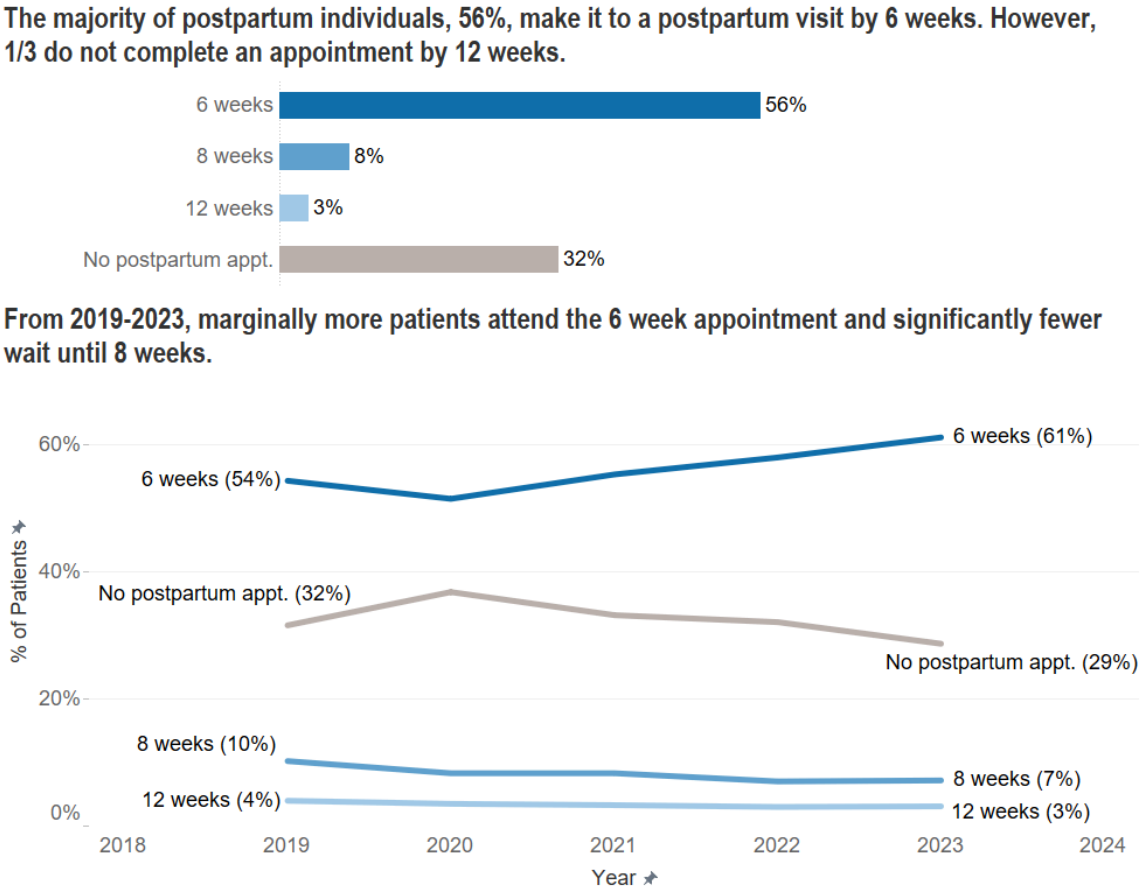

Figure 2. Postpartum appointment visits by time of visit (6, 8, or 12 weeks) on average (top graph) and by year (bottom graph). The slope for percent of patients attending a 6 week appointment increased marginally, p=.06, while the slope for percent of patients attending an 8 week appointment fell significantly, p=.03.

Implications: While 7 in 10 patients attend postpartum visits by 12 weeks, significant opportunity remains to ensure postpartum visits occur for the 3 in 10 patients who do not. Postpartum appointments provide a key opportunity to address obstetric and mental health conditions that drive maternal morbidity and mortality, and higher attendance can increase mental health screening and referral to treatment.

Takeaways and next steps

Promising Trends

- **Improved detection of mental health conditions:** The increase in perinatal mental health diagnoses, particularly for depression and anxiety, may signal greater mental health burden

during this study period, which included the COVID-19 pandemic. It may also reflect improved screening and documentation practices and expanded behavioral health access made possible by payors, and especially Colorado's Medicaid program, between 2019-2023.

- **Increased engagement in mental health care:** A greater proportion of patients with a mental health diagnosis accessed mental health services over time, and patients attended more mental health appointments in 2023 than in 2019. This may also reflect expanded access to care made possible during the study period via telehealth pathways and insurance coverage.
- **70% attend a postpartum visit by 12 weeks, and more attend earlier:** 70% of patients are attending postpartum visits by 12 weeks. More patients are attending postpartum visits at six weeks rather than eight, reflecting growing adoption of best practice guidelines for earlier and continuous postpartum follow-up.
- **Small improvement in postpartum visit completion:** The proportion of individuals with no postpartum visit declined modestly from 32% to 28%, showing progress toward more consistent postpartum care.

Areas of Opportunity

- **Expand access to mental health services:** Most individuals with a mental health diagnosis do not receive any mental health treatment, particularly during pregnancy. Earlier and more consistent access to mental healthcare could prevent worsening conditions postpartum.
- **Support sustained treatment engagement:** Even among those who access care, most do not complete a full course of therapy. Strengthening referral processes, reducing logistical and financial barriers, and increasing continuity between obstetric, primary care, and mental health providers could improve treatment adherence and outcomes. Increased access to peer support, perinatal navigation services, and provider training on perinatal mental health conditions may also increase likelihood of engaging in sustained treatment.
- **Sizable missed opportunity in postpartum care:** Nearly one in three patients do not attend a postpartum visit within 12 weeks, missing a critical opportunity for physical and mental health assessment. Enhanced care coordination and patient follow-up systems, as well as patient and provider education on the importance of postpartum follow-up visits, could help ensure timely postpartum contact.
- **Integrate mental health within perinatal care systems:** Integrated care—linking obstetric, primary care, and behavioral health providers—remains essential to ensure that mental health needs are recognized, referred, and effectively treated as part of routine perinatal care. Increased awareness of mental health-specific resources for perinatal providers, like Colorado's PROSPER program for provider-to-provider perinatal psychiatry support and referrals, is key to expanding capacity.

Resources

- Full report: Developed by the Center for Improving Value in Health Care (CIVHC) and subsequently edited by CPCQC for clarity and interpretation
- Data tables: Produced by CIVHC
- Maternal Mental Health Overview Fact Sheet (Maternal Mental Health Leadership Alliance)

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