MATERNAL HEALTH INNOVATIONS (MHI)

# Data Snapshot Companion

## Priority Area: Mental Health

Washington State Department of HEALTH

**DOH 141-245 February 2026 CS**

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# Information About the Data Snapshots

The Maternal Health Innovation (MHI) Data Snapshots (DS) are designed to help each priority area workgroup focus attention on their specific main issues. Each snapshot offers a compact, updated summary of the current data for their respective MHI priority area: Substance Use and Mental Health, Obstetric Care Quality, Rural Access to Care, and Community-Based Perinatal Care and Support.

This companion document focuses on the **Mental Health Priority Area** and provides additional context and expanded definitions to support the priority area's actionable insights for decision-making and strategy development.

**We grouped the data points into 3 categories for each MHI priority area:**

- Maternal health outcomes
- Maternal health factors
- Additional considerations (qualitative data)

The DS tables reflect the most recent data available by March 31, 2025. Due to space limitations, they only include categories with notable values or those representing the range of values across groups. A complete list of available categories for each data point — along with additional indicators, is included in this companion document.

## How Can I Use These Data Snapshots?

This companion document can support your project planning, evaluation, and decision-making. Here are some ways to apply the information:

- **Identify key outcomes and factors.**

  Review the data snapshots to find the maternal health outcomes and maternal health factors most relevant to your priority area work.
  - What initial insights do the data points offer?
  - Which indicators provide new information or confirm what you already know?

- **Tailor priority area project activities.**

  Use the data to shape your project activities.
  - Should some of your workgroup project activities focus on specific subpopulations?

- **Define evaluation and monitoring measures.**

  Discuss with your team if these data points can be adapted to measure progress on your priority area workgroup projects.
  - Is there any data not included in the DS that you would like access to?
  - If yes, consider whether your group project should include additional data collection activities.

## Working Definitions

### Race and Ethnicity Categories

The DS uses the following race and ethnicity categories:

- Hispanic: Anyone with Hispanic or Latino ethnicity, regardless of race
- Non-Hispanic (NH) single-race: Individuals who identify as one race. For example, AIAN means single-race NH American Indian/Alaska Native individuals, and NHPI means single-race NH Native Hawaiian/Pacific Islander.
- Non-Hispanic multiple races: Individuals reporting 2 or more races.

### Significant Difference

When interpreting DS data points, we use the term significant difference to refer to statistically notable differences between groups.

To determine whether the differences between groups are meaningful or due to chance, we used both confidence intervals (CI) [1] and p-values[2] (1,2). Here's how we assessed the differences:

- Two-group comparisons: A difference is considered significant if the CIs of the comparison groups do not overlap. This suggests the two groups likely differ with a certain level of confidence (e.g., 95%).
- Multiple-group comparisons: In a statistical test comparing multiple groups, we considered differences between groups significant when the p-value associated with that test was below .05 ($p < .05$).

**Important Note:** We recognize that public health practice and policy decisions shouldn't solely be based on p-value thresholds or CI overlaps.

**Desired Direction:** Each indicator has a "desired direction" toward improvement and positive outcomes:

- Increase = Higher is better
- Decrease = Lower is better
- Neutral = Neither direction is better.

For example, a decrease is the desired direction for smoking during pregnancy meaning a lower percentage of this indicator would be considered an improvement.

1 A CI provides an interval estimate or range of values that acknowledge the uncertainty of the single number point estimate, particularly one that is based on a sample of the population

2 A p-value is the probability under a specified statistical model that a statistical summary of the data (e.g., the sample mean difference between two compared groups) would be equal to or more extreme than its observed value

## Narrative Overview of Each Indicator

This section provides a narrative overview of all the indicators included in the DS tables, along with other related indicators. For each indicator, you will find:

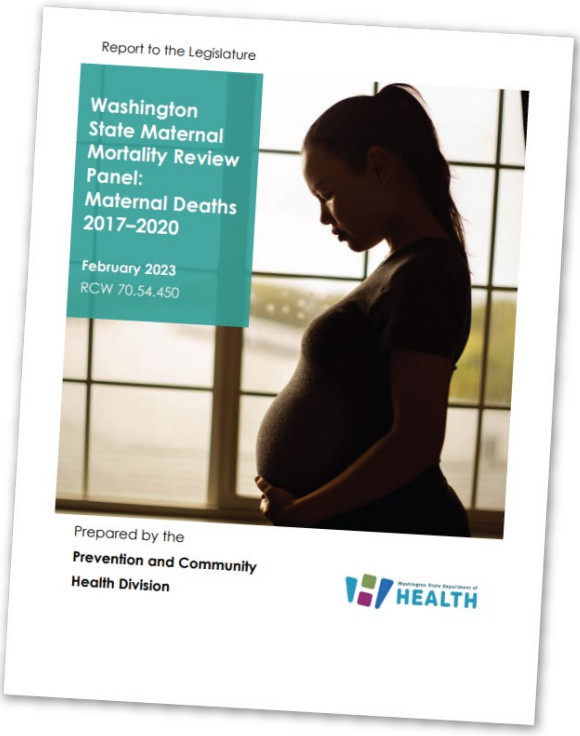
- Indicator name
- Year the data was obtained
- If appropriate, the desired indicator direction
- Indicator definition
- Original data source with a summary table or figure

The definitions reflect those used by the original data source and can also be found below the DS tables.

# Maternal Health Outcomes

## Pregnancy-Related Deaths (2014–2020) – Lower Rates are Desirable

Pregnancy-related deaths per 100,000 live births refer to deaths that occur during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by a pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy, as determined by the Washington Maternal Mortality Review Panel (MMRP) (3).




The table on the following page illustrates pregnancy-related deaths included in the 2023 WA MMRP Report (3). The table presents both frequencies and rates. Frequency, the total number of deaths in each subgroup, shows the magnitude of deaths. Rates, the number of deaths per 100,00 live births, highlight differences in outcomes across subgroups.

**Table 1. Pregnancy-Related Deaths by Maternal Age, Race and Ethnicity, Coverage Type and County of Residence (2014–2020, Washington)**

| Maternal Mortality | Rate per 100,000 | 95% Confidence Interval |
|---|---|---|
| Statewide (n=97) | 15.9 | (12.9, 19.4) |
| *By Maternal Age** | | |
| <25 Years (n=18) | 14 | (8, 21) |
| 25-34 Years (n=48) | 13 | (10, 17) |
| ≥ 35 Years (n=31) | 26 | (18, 36) |
| *By Maternal Race and Ethnicity** | | |
| AIAN NH (n=7) | 84 | (34, 156) |
| NHPI NH (n=4) | 48 | (13, 106) |
| Black NH (n=10) | 36 | (17, 61) |
| Hispanic (n=21) | 19 | (12, 28) |
| White NH (n=46) | 13 | (9, 17) |
| *By Insurance Coverage Type** | | |
| Medicaid (n=66) | 28 | (22, 35) |
| Private (n=24) | 8 | (5, 11) |
| *By County of Residence* | | |
| Urban County (n=82) | 15 | (12, 19) |
| Rural County (n=15) | 23 | (13, 36) |

Data Source: Washington State MMRP: Maternal Deaths 2014-2020

* = differences between certain categories of this indicator were statistically significant based on non-overlapping Confidence Intervals (CI)

## Leading Causes of Pregnancy-Related Death with Average Time Between End of Pregnancy and Death (2014–2020)

The underlying cause of death refers to the disease or injury that initiated the chain of events leading to death, or the circumstances of the accident or violence which produced the fatal injury. This includes deaths that occurred during pregnancy or up to 1 year after the end of pregnancy.

**Table 2** illustrates the average time between the end of pregnancy and death for the top 3 leading causes of 2014 to 2020 pregnancy-related deaths from the 2023 WA MMRP Report (3).

**Table 2. Leading Causes of Pregnancy-Related Deaths and Average Time Between End of Pregnancy and Death (2014–2020 in Washington)**

| Cause of Pregnancy-Related Death | Number (Percent of Total) | Average Time (Range) |
|---|---|---|
| Behavioral Health | n=31 (32%) | 115.4 days/16 weeks (0–344 days) |
| Hemorrhage | n=12 (12%) | 11.5 days (0–124 days) |
| Infection | n=9 (9%) | 10.2 days (0–41 days) |

Data Source: Washington State MMRP: Maternal Deaths 2014–2020

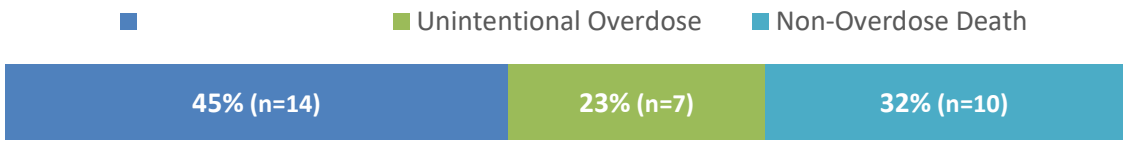
**Notes on Leading Causes (Pregnancy-Related Deaths):**

- Behavioral health conditions include mental health conditions and substance use. These deaths may involve suicides, unintentional substance overdose, and other non-overdose deaths related to substance use, such as infection, injury, cardiovascular conditions, or mental health conditions.
- Hemorrhage deaths include cervical laceration, ectopic pregnancy, uterine rupture, falling, and other non-specified hemorrhage.
- Infection deaths include COVID-19, sepsis due to infections of the amniotic sac and membranes, and sepsis due to an unknown cause.

## Behavioral Health Pregnancy-Related Deaths (2014–2020)

Among the 31 behavioral health pregnancy-related deaths from 2014 to 2020 (3), causes of death vary and include deaths by suicide, unintentional overdose, and non-overdose deaths in which substance use contributed (e.g., infection related to intravenous substance use).

**Figure 1. Causes of Death for Behavioral Health Pregnancy-Related Deaths (2014–2020, Washington) (n=31)**

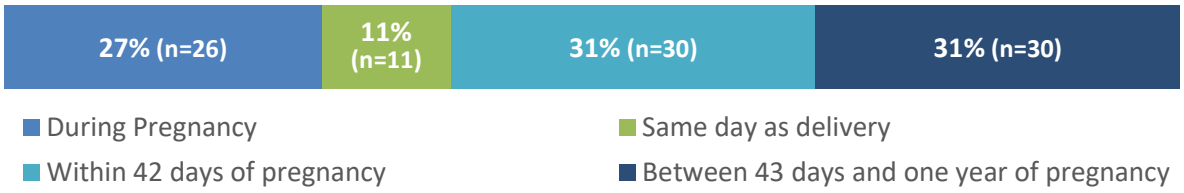



Data Source: Washington State Maternal Mortality Review Panel (MMRP): Maternal Deaths 2014–2020

## Average Time Between Pregnancy and Death for Pregnancy-Related Deaths (2014–2020)

- More than one-quarter (27%) of the pregnancy-related deaths in 2014 to 2020 occurred during pregnancy.
- 11% occurred within 24 hours of delivery.
- Almost one-third (31%) of pregnancy-related deaths occurred within 42 days after the end of pregnancy.
- 31% occurred beyond 43 days after the end of pregnancy (3).

**Figure 2. Average time between Pregnancy and Pregnancy-Related Death for Pregnancy-Related deaths (2014–2020 in Washington) (n=97)**




Data Source: Washington State Maternal Mortality Review Panel (MMRP): Maternal Deaths 2014–2020

## Severe Maternal Morbidity (2022) – Lower Rates Are Desirable

Severe Maternal Morbidity (SMM) is defined as unexpected outcomes of labor and delivery that can result in significant short- and long-term health consequences (4).

SMM events are identified as in-hospital deliveries of female patients aged 12–55 years with a diagnosis or procedure indicating SMM documented in their discharge record. This indicator includes SMM by maternal age, maternal race and ethnicity, hospital delivery volume, and expected payer.

Hospital delivery volume is the number of deliveries at an individual facility each year. Expected payer is the type of payer that the hospital expects to be the source of payment for the hospital bill.

SMM deliveries are identified among all in-hospital deliveries of patients treated in community hospitals in Washington[3]. The data includes deliveries of both people living in Washington state and people living outside of Washington who gave birth at Washington facilities (5).

From 2016 to 2022, the overall rate of SMM in the US increased from 72 to 93.1 per 10,000 in-hospital deliveries. In the same period, the SMM rates increased in WA from 58.3 in 2016 to 100.0 in 2022.

3 Community hospitals include short-term, non-Federal, general, and other hospitals excluding hospital units of other institutions (e.g. prisons) or community hospitals that are also long-term care facilities.

**Table 3. SMM Rates per 10,000 In-Hospital Deliveries (2022, Washington)**

| SMM | Rate per 10,000 |
|---|---|
| Statewide | 100.0 |
| **By Maternal Age** | |
| < 20 Years | 86.1 |
| 20-24 Years | 86.4 |
| 25-34 Years | 92.6 |
| ≥ 35 Years | 128.3 |
| **By Maternal Race and Ethnicity†** | |
| Black NH | 170.1 |
| Hispanic | 105.8 |
| White NH | 86.8 |
| Other, NH‡ | 132.1 |
| **By Hospital Delivery Volume** | |
| <500 Deliveries | 60.4 |
| 500-1,000 Deliveries | 54.1 |
| >1,000 Deliveries | 108.0 |
| **By Expected Payer** | |
| Medicaid and Medicare§ | 105.5 |
| Private Insurance | 98.0 |

Data Source: HCUP Fast Stats, Severe Maternal Morbidity (SMM) Among In-Hospital Deliveries in WA; †SMM rate by maternal race and ethnicity is from 2021; ‡The non-Hispanic Other category includes Asian or Pacific Islander, American Indian/Alaska Native, and other non-Hispanic race identified as "other". Discharges missing race/ ethnicity are excluded from results reported by race/ethnicity. §On average, Medicare represents fewer than 1% of in-hospital deliveries.

# Mental Health Factors and Outcomes

## Pregnancy Risk Assessment Monitoring System (2020–2022)

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a survey of new birthing parents conducted by the WA State Department of Health and the Centers for Disease Control and Prevention (CDC) (6). PRAMS gathers information from birthing people about their experiences before, during, and after their most recent pregnancy.

In the data snapshot, PRAMS data is reported as the percentage of people living in Washington who had a live birth in-state between 2020–2022.

## Pre-pregnancy Health Care Visit for Anxiety or Depression

The table below summarizes self-reported health care visits for anxiety or depression with doctors, nurses, or mental health workers in the 12 months before pregnancy as a percentage of all Washington residents with a live birth in Washington in 2020–2022 (6).

**Table 4. Pre-pregnancy Health Care Visits for Anxiety or Depression (2020–2022, Washington)**

| Pre-pregnancy Health Care Visit for Anxiety or Depression | Percent | 95% Confidence Interval |
|---|---|---|
| Statewide | 17% | (15%, 19%) |
| *By Maternal Race and Ethnicity* | | |
| AIAN NH | 22% | (17%, 29%) |
| White NH | 19% | (17%, 23%) |
| Black NH | 15% | (12%, 20%) |
| Multiracial NH | 15% | (10%, 22%) |
| Hispanic | 14% | (11%, 19%) |
| Asian NH | 7% | (4%, 10%) |
| NHPI NH | Not Available | |
| *By Maternal Age** | | |
| < 20 Years | Not Available | |
| 20-24 Years | 29% | (22%, 38%) |
| 25-29 Years | 21% | (17%, 26%) |
| 30-34 Years | 12% | (9%, 15%) |
| 35-39 Years | 13% | (10%, 17%) |
| ≥ 40 Years | 15%[NR] | (9%, 26%) |

Data Source: WA PRAMS (2020–2022); * = differences between categories were significant (p <.05).

Not Available = Relative Standard Error (RSE) is over 30%; estimates are excluded due to unreliability.

NR (Not Reliable) = Relative Standard Error (RSE) is between 25–30%; estimates may be unreliable and should be interpreted with caution.

## Three or More Stressors in the 12 Month Before Delivery – Lower Percentages are Desirable

This measure is the percentage of all Washington residents with a live birth in Washington in 2020-2022 that reported experiencing at least three of the listed stressors in the year before delivery (6).

The list of the stressors include: sick family member; separation or divorce; recently moved; homelessness; husband/partner lost job; lost own job; husband/partner/self had cut in work hours or pay; apart from husband/partner due to military/work; argued with husband/partner more than usual; husband/partner didn't want pregnancy; problems paying the rent, mortgage, or other bills; someone very close had problem with drinking or drugs; someone very close died.

**Table 5. Three or More Stressors in the 12 Months Before Delivery (2020–2022, Washington)**

| Pre-pregnancy Health Care Visit for Anxiety or Depression | Percent | 95% Confidence Interval |
|---|---|---|
| Statewide | 25% | (23%, 27%) |
| *By Maternal Race and Ethnicity** | | |
| AIAN NH | 45% | (40%, 50%) |
| NHPI NH | 44% | (29%, 61%) |
| Multiracial NH | 38% | (31%, 46%) |
| Black NH | 35% | (31%, 39%) |
| Hispanic | 25% | (21%, 28%) |
| White NH | 25% | (22%, 28%) |
| Asian NH | 10% | (8%, 13%) |
| *By Maternal Age** | | |
| < 25 Years | 38% | (33%, 43%) |
| 25-34 Years | 24% | (21%, 26%) |
| ≥ 35 Years | 19% | (16%, 22%) |

Data Source: WA PRAMS (2020-2022); * = differences between categories were significant (p <.05).

## Discrimination in the 12 Months Before Delivery – Lower Percentages are Desirable

This measure is the percentage of all Washington residents with a live birth in Washington in 2020–2022 that reported experiencing discrimination for any reason in the year before delivery (6).

PRAMS survey participants are asked if they experienced any discrimination, harassment, or were made to feel inferior because of race, ethnicity or culture; insurance or Medicaid status; weight; marital status; or any other reason in the 12 months before delivery.

**Table 6. Experienced Discrimination in the 12 Months Before Delivery (2020–2022, Washington)**

| Discrimination in 12 Months Before Delivery | Percent | 95% Confidence Interval |
|---|---|---|
| Statewide | 16% | (15%, 18%) |
| *By Maternal Race and Ethnicity** | | |
| Multiracial NH | 35% | (26%, 44%) |
| Black NH | 28% | (24%, 32%) |
| AIAN NH | 28% | (23%, 33%) |
| Hispanic | 17% | (14%, 20%) |
| White NH | 13% | (11%, 16%) |
| Asian NH | 12% | (9%, 15%) |
| NHPI NH | Not Available | |
| *By Maternal Age* | | |
| < 20 Years | 25%[NR] | (15%, 40%) |
| 20-24 Years | 19% | (15%, 25%) |
| 25-29 Years | 18% | (15%, 22%) |
| 30-34 Years | 15% | (12%, 18%) |
| 35-39 Years | 14% | (11%, 18%) |
| ≥ 40 Years | 12%[NR] | (7%, 21%) |

**Data Source:** WA PRAMS (2020–2022); * = differences between categories were significant (p <.05).

**Not Available =** Relative Standard Error (RSE) is over 30%; estimates are excluded due to unreliability.

**NR (Not Reliable) =** Relative Standard Error (RSE) is between 25–30%; estimates may be unreliable and should be interpreted with caution.

## Experienced Abuse or Violence During Pregnancy – Lower Percentages are Desirable

This measure is the percentage of all Washington residents with a live birth in Washington in 2020-2022 that reported experiencing abuse or violence from an ex or current husband or partner during pregnancy (6).

Participants were asked if a current husband, current partner, ex-husband, or ex-partner had pushed, hit, slapped, kicked, choked, or physically hurt them in another way or if a husband or partner had threatened, made them to feel unsafe, frightened them for their own or family's safety because of anger or threats, tried to control their daily activities, or forced them to take part in sexual activity when they didn't want to.

**Table 7. Experienced Abuse or Violence During Pregnancy (2020–2022, Washington)**

| Experienced Abuse or Violence During Pregnancy | Percent | 95% Confidence Interval |
|---|---|---|
| Statewide | 4% | (3%, 5%) |
| *By Maternal Race and Ethnicity* | | |
| AIAN NH | 9% | (7%, 13%) |
| Black NH | 6% | (4%, 8%) |
| Multiracial NH | 5% | (3%, 8%) |
| White NH | 4% | (3%, 5%) |
| Hispanic | 4% | (3%, 6%) |
| Asian NH | Not Available | |
| NHPI NH | Not Available | |
| *By Maternal Age** | | |
| < 25 Years | 9% | (7%, 13%) |
| 25-34 Years | 3% | (2%, 4%) |
| ≥ 35 Years | 3% | (2%, 5%) |

Data Source: WA PRAMS (2020–2022); * = differences between categories were significant (p <.05).

Not Available = Relative Standard Error (RSE) is over 30%; estimates are excluded due to unreliability.

## Depression During Pregnancy – Lower Rates are Desirable

This measure is the percentage of all Washington residents with a live birth in Washington in 2020-2022 who self-reported having depression during their most recent pregnancy (6).

**Table 8. Experienced Depression During Pregnancy (2020–2022, Washington)**

| Depression During Pregnancy | Percent | 95% Confidence Interval |
|---|---|---|
| Statewide | 16% | (15%, 18%) |
| *By Maternal Race and Ethnicity** | | |
| AIAN NH | 26% | (22%, 31%) |
| Multiracial NH | 23% | (17%, 30%) |
| White NH | 19% | (16%, 21%) |
| Black NH | 17% | (14%, 21%) |
| Hispanic | 13% | (11%, 16%) |
| Asian NH | 9% | (6%, 12%) |
| NHPI NH | Not Available | |
| *By Maternal Age** | | |
| < 20 Years | 22%[NR] | (13%, 34%) |
| 20-24 Years | 23% | (18%, 28%) |
| 25-29 Years | 21% | (18%, 24%) |
| 30-34 Years | 13% | (10%, 15%) |
| 35-39 Years | 12% | (9%, 15%) |
| ≥ 40 Years | 14% | (9%, 22%) |

Data Source: WA PRAMS (2020–2022); * = differences between categories were significant (p <.05).

Not Available = Relative Standard Error (RSE) is over 30%; estimates are excluded due to unreliability.

NR (Not Reliable) = Relative Standard Error (RSE) is between 25–30%; estimates may be unreliable and should be interpreted with caution.

## Postpartum Depression – Lower Rates are Desirable

This measure is the percentage of all Washington residents with a live birth in Washington in 2020–2022 that were identified as experiencing postpartum depression (6).

PRAMS respondents were identified as having postpartum depression if they self-reported feeling down, depressed, or hopeless or having little interest or little pleasure in doing things they usually enjoy.

**Table 9. Experienced Postpartum Depression (2020–2022, Washington)**

| Postpartum Depression | Percent | 95% Confidence Interval |
|---|---|---|
| Statewide | 12% | (11%, 13%) |
| *By Maternal Race and Ethnicity** | | |
| AIAN NH | 18% | (15%, 23%) |
| Black NH | 18% | (14%, 22%) |
| Multiracial NH | 16% | (10%, 23%) |
| Hispanic | 12% | (10%, 15%) |
| Asian NH | 12% | (9%, 15%) |
| White NH | 11% | (9%, 13%) |
| NHPI NH | Not Available | |
| *By Maternal Age** | | |
| < 20 Years | Not Available | |
| 20-24 Years | 16% | (12%, 21%) |
| 25-29 Years | 14% | (11%, 17%) |
| 30-34 Years | 11% | (9%, 13%) |
| 35-39 Years | 9% | (7%, 12%) |
| ≥ 40 Years | Not Available | |

Data Source: WA PRAMS (2020–2022); * = differences between categories were significant (p <.05).

Not Available = Relative Standard Error (RSE) is over 30%; estimates are excluded due to unreliability.

## Postpartum Health Care Visit – Higher Rates are Desirable

This measure is the percentage of all Washington residents with a live birth in Washington in 2020-2022 that reported having had a postpartum checkup since their new baby was born (self-reported, as of time of survey) (6).

**Table 10. Postpartum Health Care Visit After Delivery (2020–2022, Washington)**

| Postpartum Health Care Visit After Delivery | Percent | 95% Confidence Interval |
|---|---|---|
| Statewide | 91% | (90%, 93%) |
| *By Maternal Race and Ethnicity** | | |
| Asian NH | 96% | (94%, 97%) |
| White NH | 91% | (89%, 93%) |
| Multiracial NH | 91% | (84%, 95%) |
| Hispanic | 91% | (88%, 93%) |
| Black NH | 87% | (83%, 90%) |
| NHPI NH | 84% | (69%, 92%) |
| AIAN NH | 83% | (78%, 86%) |
| *By Maternal Age** | | |
| < 20 Years | 78% | (64%, 87%) |
| 20-24 Years | 88% | (84%, 92%) |
| 25-29 Years | 92% | (90%, 94%) |
| 30-34 Years | 92% | (90%, 94%) |
| 35-39 Years | 93% | (91%, 95%) |
| ≥ 40 Years | 96% | (91%, 98%) |

Data Source: WA PRAMS (2020-2022); * = differences between categories were significant (p <.05).

# Acknowledgments

These **Data Snapshots** were prepared by epidemiologists in the Perinatal through Early Childhood Assessment & Reporting (PEAR) and Surveillance & Evaluation (SE) sections in the Office of Family and Community Health Improvements (OFCHI). The data included in these snapshots was provided by teams across the Washington State Department of Health.

We would like to thank our colleagues who supported this work, especially the epidemiologists from PEAR and SE in OFCHI.

# Data Sources

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