The Maryland

Maternal Health Improvement

STRATEGIC PLAN

Developed by the Maryland Maternal Health Improvement Task Force

September
2025

Acknowledgments

The Maryland Maternal Health Improvement Task Force thanks all the women in our State who have offered their stories to guide the Task Force to develop this plan. This plan is based on the premise that every woman in the State of Maryland should have the opportunity to thrive during her lifetime.

The collective, passionate efforts of the Task Force members have resulted in a thoughtful and forward-looking plan that will guide our State over the next 5 years. Thank you for your time, expertise and unwavering focus on our shared vision and goals.

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Maryland Maternal Health Improvement Strategic Plan

The Maryland Maternal Health Strategic Plan outlines how agencies, organizations, community groups, and residents will work together to reduce maternal deaths and pregnancy complications in Maryland over the next five years. The World Health Organization defines maternal health as the health of the woman during pregnancy, during delivery, and in the postpartum period. Along with infant mortality, indicators such as severe maternal morbidity and maternal mortality are widely considered to reflect the overall health and well-being of a community.

In September 2019, Maryland was one of nine states selected to be part of a nationwide State Maternal Health Innovation Program with the Health Resources and Services Administration.

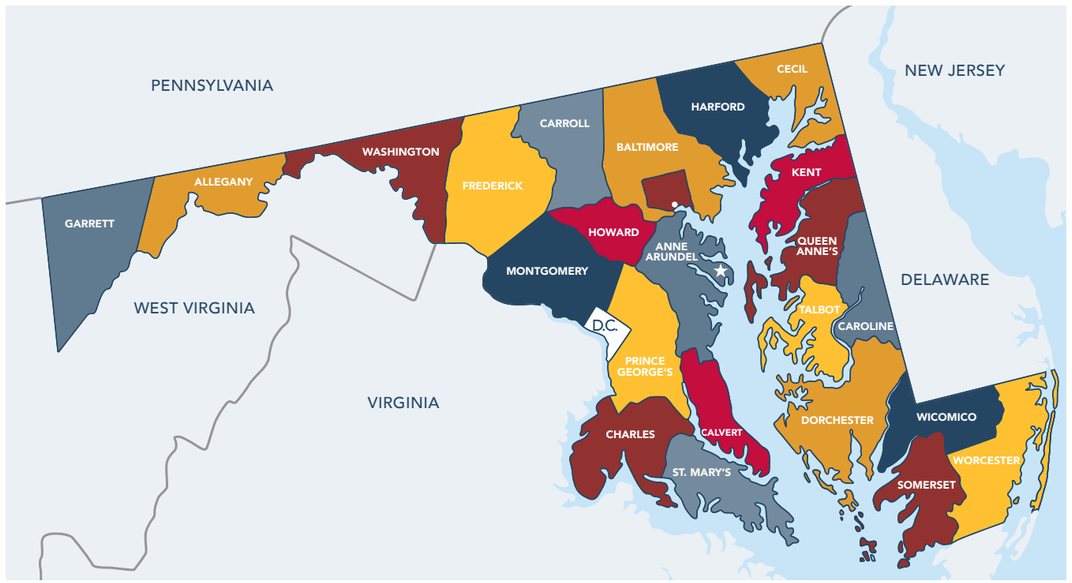
Led by Johns Hopkins University, MDMOM is a five-year initiative to improve maternal health in Maryland. Other partners include the Maryland Patient Safety Center and the Maryland Department of Health. As part of MDMOM, a Maternal Health Improvement Task Force was established to coordinate programs and policies to improve the health and well-being of pregnant and postpartum women in Maryland. The Task Force was first charged in 2020 with developing a five-year strategic plan to improve maternal health in Maryland, building upon the 2020 Maryland Title V Needs Assessment and updating that plan every five years. The Task Force developed the first Strategic Plan in 2021. This 2025 strategic plan builds on the 2021 Strategic Plan with input from the Maternal Health Improvement Task Force members. It also includes the input of key stakeholders representing hospital systems, community health and social services organizations, and government agencies, as well as information from the most recently conducted 2025 Title V Maternal and Child Health Needs Assessment.

Brief Overview of Maryland

Maryland is comprised of 24 jurisdictions, including 23 counties and the city of Baltimore. Maryland is geographically unique, with the Allegheny Mountains and Chesapeake Bay separating its western and eastern regions from the central population centers of the state. With an estimated population of more than 6 million in 2023, Maryland is the nation's 18th most populous state.

The State's maternal health population includes an estimated 1.2 million women of childbearing age (ages 15–44). In calendar year 2023, there were 65,578 live births, which included 25,603 Non-Hispanic White births (39.0%), 18,791 Non-Hispanic Black births (28.7%), 4,328 Non-Hispanic Asian/Pacific Islander births (6.6%), 71 American Indian births (0.1%), and 14,425 Hispanic births of all races (22.0%).

Maryland's health care system includes 24 local health departments (LHDs), 77 hospitals, 16 federally qualified health centers (FQHCs), the Medicaid Program, private insurers, regulatory agencies, provider groups, advocacy groups, and health practitioners. Maternal and child health (MCH) specific resources include 32 birth hospitals, nearly 2,300 pediatricians and adolescent practitioners, 1,100 obstetricians and gynecologists, 700 advanced practice women's health nurses and midwives, and 1,700 family/general practitioners.



Among Maryland's 24 counties, Queen Anne's and Somerset are categorized as maternity care deserts by the March of Dimes. A maternity care desert is defined as a jurisdiction without a hospital or birth center offering obstetric care and without any obstetric clinician (obstetrician, family practice physician who delivers babies, or midwife). Two additional counties, Caroline and Dorchester, are categorized as having moderate access to maternity care. Moderate access is defined as one or fewer birth hospitals, birth centers, or obstetric clinicians or 10% or less of reproductive-aged women uninsured.[1]

Maternal Health in Maryland: Strengths and Challenges

Title V Needs Assessment

Maryland's lead public health agency is the Maryland Department of Health, headed by Secretary Dr. Meena Seshamani, who was appointed in April 2025. Maryland Department of Health houses Title V in the Maternal and Child Health Bureau within the Prevention and Health Promotion Administration. The Bureau's mission is to ensure that MCH populations have reached their full health potential and improve the health and well-being of all individuals, families, and communities in Maryland.

The mission of Maryland Title V is to protect, promote, and improve the health and well-being of all women, infants, children and adolescents. Maryland Title V work strengthens the maternal and child health infrastructure in the state to ensure the availability, accessibility, and quality of primary and specialty care services for women, infants, children and adolescents, with special consideration for those children and youth with specific health care needs. As Maryland's Title V Maternal and Child Health Block Grant recipient, the Maryland Department of Health's Maternal and Child Health Bureau provides the leadership to implement strategies focused on improving the health and well-being of maternal and child health populations across the state. MCHB staff partners across other bureaus and offices within the Department and collaborate with other state agencies to fulfill Title V's mission.

[1] March of Dimes. Maternity Care Deserts. https://www.marchofdimes.org/peristats/data?reg=99&top=23&stop=641&lev=1&slev=4&obj=18&sreg=24. Accessed August 18, 2025.

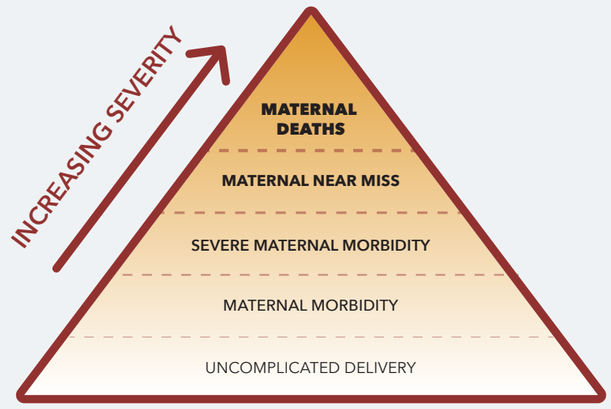
As the Title V Maternal and Child Health Needs Assessment was recently completed (between May 2024 and April 2025), information from the Title V needs assessment is also reflected in the Maryland Maternal Health Improvement Strategic Plan. The Title V Needs Assessment also consisted of six stages: 1) a planning stage that included the initial meeting with the Steering Committee and a formal research plan; 2) gathering existing data from a variety of data sources to better understand the population needs, available services, and differences in health care access and health outcomes; 3) broad-based stakeholder input, including 5 key informant interviews, 5 community focus groups, distribution of a survey to community partners, and 8 MCH workforce listening sessions; 4) identifying priorities through strategic planning sessions with key stakeholders; and 5) report development. Public comment on the needs assessment will be solicited as part of the larger Title V application comment period. The 2025 Title V Needs Assessment has identified nine priorities across six domains:

- Priority #1: Ensure that all women are in optimal health before, during, and after pregnancy
- Priority #2: Address drivers for Severe Maternal Morbidity (SMM), with a focus on chronic conditions and comorbidities
- Priority #3: Ensure that all babies have the best possible start and thrive in their first year
- Priority #4: Ensure that culturally congruent, comprehensive physical, social, and mental health services are available to every child in Maryland when they need them
- Priority #5: Ensure that adolescents aged 12-17 receive developmentally appropriate, youth-centered, comprehensive health care that addresses holistic needs
- Priority #6: Maximize the health outcomes of children and youth with specific healthcare needs through family-centered, comprehensive and coordinated care
- Priority #7: Ensure a successful transition from pediatric health care to adult health care
- Priority #8: Ensure that the Maryland Department of Health's Maternal and Child Health Bureau [MCHB] policies and processes are centered on data and experiences of Maryland's population to address differing health needs
- Priority #9: Support the integration of mental health and emotional well-being approaches for the MCH population across the life course

Maryland Maternal Health Data

Severe Maternal Morbidity and Mortality. Figure 1 illustrates the spectrum of maternal health outcomes. At the base of the pyramid are healthy women who experience no complications. At the top of the pyramid are the most extreme end of the continuum: those who experience severe complications during pregnancy or those who die during pregnancy or afterwards. Instances of both maternal mortality and severe maternal morbidity are considered sentinel events that emphasize critical issues in maternal health. Differences by race and socio-economic status in these adverse outcomes indicate gaps in the availability of quality health care services that address the needs of each patient.

FIGURE 1: SPECTRUM OF SEVERE MATERNAL MORBIDITY AND MORTALITY



Maternal Mortality. One measure of maternal mortality tracks maternal deaths, which the World Health Organization defines as "the annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy."[2] In the beginning of the 20th century, the maternal mortality ratio (MMR) in the U.S. was approximately 850 deaths per 100,000 births. The ratio dropped throughout the century, reaching its low point of about 7/100,000 in the early to mid-1980s—a 99% reduction in the ratio from the beginning of the century.

[2] CDC. Detailed evaluation of changes in data collection methods. https://www.cdc.gov/nchs/maternal-mortality/evaluation.htm

However, since the late 1980s, the MMR has been increasing. It is estimated that 40%-50% of this increase is an artifact resulting from two efforts aimed at more complete data collection of maternal deaths, which are widely believed to have been underreported.[3] During the 1990s, ICD-10 O-codes, which account for late, (i.e., post—42 day) pregnancy-related deaths, (and also pregnancy-associated deaths not directly related to the pregnancy,) were introduced; and in the 2000s, a pregnancy checkbox was added to state death certificates. These changes, along with a central data collection and review center established in 1986, the CDC Pregnancy-Related Mortality Surveillance System (PMSS), helped address under-reporting issues. While the maternal mortality ratio is technically not a rate, to align with the Centers for Disease Control and Prevention (CDC) as well as the National Center for Health Statistics, MMR will refer to Maternal Mortality Rate.

However, accounting for these changes, there remains a "real" increase in MMR of over 50% since the 1980s. The U.S. MMR was 18.6 maternal deaths per 100,000 live births in 2023, an increase from the 2018 rate of 17.4. Nationally, the racial difference in MMR is pronounced: 50.3 deaths per 100,000 live births for non-Hispanic Black women compared to 14.5 for non-Hispanic White women, which is 3.5 times greater.

For the purposes of this report, the Maryland MMR was calculated using the CDC Wonder data,[4] and the ICD-10 codes used to identify maternal deaths are A34, O00-O95, and O98-O99. A five-year average of Maryland's MMR is used to compare it with the national MMR, as averaging the Maryland ratio stabilizes the number and is necessary because maternal deaths are relatively infrequent events that may vary considerably year to year, particularly in a small state like Maryland.

In previous years, the Maryland MMR had consistently been higher than the national average. From 2009 to 2013, the Maryland MMR was 29% higher than the national rate. However, beginning with the 2014 to 2018 period, the Maryland MMR has been less than the national rate (see Table 1). Since the 2014 to 2018 period, MMR has increased in Maryland and nationally at similar rates. Both the U.S. and Maryland rates (23.5 and 21.4 deaths per 100,000 live births, respectively) remain above the Healthy People 2030 Objective MICH-04 target of 15.7 maternal deaths per 100,000 live births.

[3] CDC. Detailed evaluation of changes in data collection methods. https://www.cdc.gov/nchs/maternal-mortality/evaluation.htm
[4] U.S. Centers for Disease Control and Prevention. CDC Wonder. https://wonder.cdc.gov. Accessed on August 18, 2025.

TABLE 1. U.S. AND MARYLAND MMR TRENDS [5]

Years	Maryland	United States
2009–2013	24.5	18.9
2014–2018	18.4	20.7
2019-2023	21.4	23.5

As noted above, Black non-Hispanic (NH) women in the U.S. had an MMR 3.5 times greater than White NH women in 2023, a difference that has persisted since the 1940s. In Maryland, the difference between the MMR for Black NH and White NH women was less pronounced for 2019-2023. Table 2 shows the MMR by race in Maryland for seven overlapping five-year periods over the past decade. Between 2010 and 2018, the gap in MMR was between 2.3 and 4.0; however, in the 2019 to 2023 period, it was 1.4. Though this change is largely indicative of an increased MMR for white women, it also represents a decrease in MMR for Black women during the period and a shift of deaths into the later postpartum period (43-365 days postpartum).

TABLE 2. FIVE-YEAR ROLLING MATERNAL MORTALITY RATE BY RACE, MARYLAND [6]

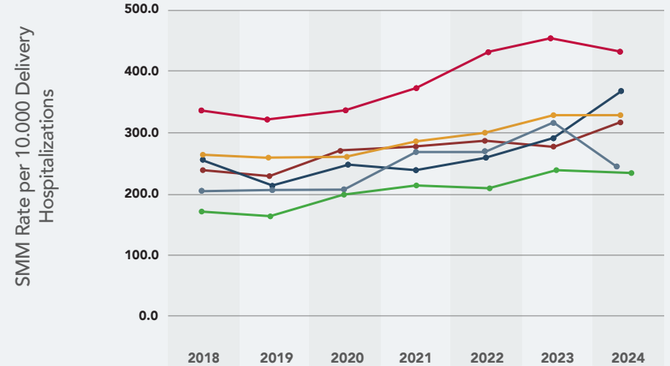
Maryland			
Year	All Races	White NH	Black NH
2009–2013	24.5	20.4	39.8
2014–2018	18.4	8.8	35.1
2019–2023	21.4	21.7	30.3

Causes of MMR. The Maryland Maternal Mortality Review Team publishes an annual report on the findings of its review. The group reviews pregnancy-associated deaths, which include deaths that occur during pregnancy and up to one year after the end of pregnancy. The most recent report, from 2022, includes a review of such deaths that occurred in 2020. Among these, the leading cause of both pregnancy-related (i.e., death is related to the pregnant state) and non-pregnancy related (i.e., death is unrelated to the pregnant state) death were behavioral health conditions. Of 17 pregnancy-related deaths, 5 were due to behavioral health conditions, 3 were due to cardiovascular conditions, and three were due to infection [note: COVID-19 was categorized as "infection" in 2020]. Of 41 non-pregnancy-related deaths, 18 were due to behavioral health conditions, 5 were due to cancer, and 4 were due to cardiovascular conditions. The majority of pregnancy-related deaths occurred during pregnancy (47%), while the majority of non-pregnancy related deaths occurred between 43 days and 1 year postpartum (63%).[7]

The leading causes of all pregnancy-associated deaths were behavioral health conditions.

Severe Maternal Morbidity. Severe maternal morbidity (SMM) is estimated to be nearly 100 times more common than maternal mortality. SMM includes unexpected outcomes of labor and delivery that result in significant short- or- long-term consequences for a woman's health.[8] The CDC conducts SMM surveillance using administrative hospital discharge data consisting of 21 indicators that include 16 diagnosis-based indicators such as acute kidney failure, sepsis, eclampsia, embolism, as well as 5 five procedure-based indicators including blood transfusion and hysterectomy.[9]

FIGURE 2. RATE OF SEVERE MATERNAL MORBIDITY BY RACE AND ETHNICITY, YEARS 2018-2024



	2018	2019	2020	2021	2022	2023	2024
TOTAL	244.2	239.3	261.0	286.6	300	319.1	317.3
Other	204.3	228.1	227.7	270.6	267.8	308.7	250.2
NH White	183.1	180.5	200.1	226.2	220.3	248.5	249.8
NH Black	339.0	323.7	338.5	381.8	428.2	453.9	427.4
NH Asian, Hawaiian, or PI	245.1	230.5	258.9	251.8	272.6	291.0	371.1
Hispanic	242.1	239.1	280.3	284.6	292.0	282.1	310.2

[5] These numbers are different from the Maryland Maternal Mortality Review Reports as the ICD-10 codes used to identify maternal deaths are A34, O00—O95, and O98—O99 rather than ICD-10 codes O00—O99, which were previously used to calculate Maternal Mortality Rate.
[6] U.S. Centers for Disease Control and Prevention. CDC Wonder. https://wonder.cdc.gov. Accessed August 18, 2025
[7] Maryland Maternal Mortality Review. 2022 Annual Report. https://health.maryland.gov/phpa/mch/Documents/MMR/2022%20MMR%20Report.pdf
[8] American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, Kilpatrick SK, Ecker JL. Severe maternal morbidity: screening and review. Am J Obstet Gynecol. 2016;215(3): B17-22.
[9] U.S. Centers for Disease Control and Prevention. Identifying severe maternal morbidity. https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/icd.html. Accessed August 18, 2025.

This definition will be used to track progress toward SMM objectives in the strategic plan, in conjunction with data from Maryland's SMM Surveillance and Review Program. As with MMR, SMM rates in Maryland are characterized by differences between racial groups (see Figure 2). Between 2018 and 2023, SMM rates increased for all racial and ethnic groups from 243.1 to 322.8 events per 10,000 delivery hospitalizations. Non-Hispanic Black individuals experienced the highest rate of SMM in the state, 462.2, and a greater increase (38%) than Marylanders overall (33%). In 2024, however, the overall rate decreased, driven by a decreasing rate for Non-Hispanic individuals.

Substance Use Disorders. According to the Maryland Department of Health's Overdose Dashboard, 1504 overdose deaths occurred between May 2024 and April 2025, 81.1% of which were opioid-related. Most opioid-related deaths were attributable to fentanyl (89.5%). Annual overdose deaths have been decreasing since 2021, when there were 2,500 deaths, and decreased 29.7% between 2023 and 2024. Women account for 452 of the total overdose deaths (30.1%), and reproductive aged women account for 197 (13%).
According to the Maryland Maternal Mortality Review Team, 2020 was the 8th consecutive year that overdose was the chief cause of pregnancy-associated death in Maryland. Among the pregnancy-associated deaths affected Non-Hispanic White women "behavioral health conditions," all but one was identified as substance use disorder. Substance use disorder or overdose accounted for 38% of deaths overall and 44% of non-pregnancy-related deaths. Fifteen of these involved opioids, specifically fentanyl. The majority of overdose deaths affected white women (59%), and the average time of death was 49 days postpartum, or just beyond the traditional 6-week end of postpartum care.[10]

Mental Health. According to 2023 Pregnancy Risk Assessment Monitoring System (PRAMS) data, 10.5% of new mothers were told by a healthcare professional that they had depression during pregnancy and 13.9% were told that they had anxiety during pregnancy.[11] In 2023, 14.1% of new mothers experienced postpartum depression and 17.5% experienced postpartum anxiety.[12]

[10] Maryland Maternal Mortality Review. 2022 Annual Report. https://health.maryland.gov/phpa/mch/Documents /MMR/2022%20MMR%20Report.pdf
[11] Maryland Department of Health. Maryland Pregnancy Risk Assessment Monitoring System (PRAMS). https://health.maryland.gov/phpa/mch/pages/prams.aspx.
[12] Maryland PRAMS 2023 data should be interpreted with caution due to low response rates.

The 2025 Maternal Mental Health State Report Card[13] gave Maryland an overall C grade, which is slightly higher than the national average, C-. Maryland did well in the insurance coverage and treatment payment domains, earning a B. However, it did markedly worse in screening and screening reimbursement, earning an F for gaps in prenatal and postpartum screening rates and accountability. The report card also highlighted gaps in the availability of residential or intensive treatment programs and non-prescribing mental health providers. Mental health was adopted as a cross-cutting priority in the 2025 Maryland Title V Needs Assessment.

Cesarean Delivery. The World Health Organization considers the ideal rate for cesarean deliveries to be 10 to 15%.[14] Cesarean deliveries can prevent injury and death in women who are at higher risk of complications during delivery, as well as prevent injury and death in their newborns. Cesarean deliveries are linked to increased risk of infections and blood clots, and many women who are not at higher risk for delivery complications receive unnecessary Cesarean deliveries.

While recent improvements in decreasing Cesarean deliveries among Nulliparous, Term, Singleton, Vertex (NTSV) births have been achieved, the proportion of NTSV live births at

[13] Policy Center for Maternal Health. 2025 Maternal Mental Health State Report Cards: Maryland. https://marylandmatters.org/wp-content/uploads/2025/05/cecf57de-8f9c-4e96-908f-f8abf29b0109.pdf.
[14] World Health Organization. WHO Statement on Cesarean Section Rates. https://www.who.int/publications/i/item/WHO-RHR-15.02. Accessed August 18, 2025.

or beyond 37.0 weeks gestation in Maryland remains higher than the Healthy People 2030 national goal of 23.6% of NTSV births being cesarean deliveries. According to the March of Dimes , in 2023, 35.0% of all births to Maryland residents occurred by cesarean delivery, and the percentage of NTSV cesarean births was 30.3.

Reducing unnecessary cesarean delivery was the goal of a 2016-2018 Maryland Perinatal and Neonatal Quality Collaborative (MDPQC) initiative. This initiative, which focused on implementing the Alliance for Innovation on Maternal Health (AIM) patient safety bundle on Safe Reduction of Primary Cesarean Birth,[15] resulted in a 6% decrease in low-risk cesarean delivery, to a rate of 27.8%. Since that time, however, rates have steadily increased.

Smoking During Pregnancy. In 2023, Maryland remained below the national average for women who smoked during pregnancy, with 2.3% of Maryland women who smoked during pregnancy, compared to 4.4% nationally.[16] Maryland has seen a downward trend in the percentage of women who smoke during pregnancy since 2013 (7.8%), while the national trend started decreasing in 2014 (7.9%). The percentage of Maryland women who smoked during pregnancy in 2023 was highest among women identifying as non-Hispanic Multiracial (4.6%), followed by American Indian or Alaska Native women (3.5%), and lowest among Hispanic women (0.4%). Maryland continues to provide a free statewide hotline to support individuals looking to stop tobacco use.[17]

Prenatal Care. The percentage of births to women who received prenatal care in the first trimester was 69.3% in 2023, similar to the 2022 rate of 69.7%, according to the Maryland Vital Statistics Administration (VSA). The percentage was lowest among Hispanic women (46.6%) following by non-Hispanic American Indian Women (58.0%), and highest among non-Hispanic white women (82.0%). Overall, 7.4% of births were to women with late or no prenatal care, among whom Hispanic (13.5%) followed by non-Hispanic Black (8.5%) women had the highest rates. According to 2023 PRAMS data, 48.8% of women reported having their teeth cleaned during pregnancy.[18]

[15] Alliance for Innovation on Maternal Health (AIM). Safe Reduction of Primary Cesarean Birth. https://saferbirth.org/psbs/safe-reduction-of-primary-cesarean-birth-old/. Accessed on August 18, 2025.
[16] Health Resources and Services Administration (HRSA). Federally Available Data (FAD) Resource Document Page. https://mchb.tvisdata.hrsa.gov/Home/FADDocuments.
[17] Maryland Department of Health. Maryland's 1-800-Quit-Now. https://smokingstopshere.com/. Accessed August 18, 2025.
[18] 2023 Maryland PRAMS data should be interpreted with caution due to low response rate.

Breastfeeding. In 2023, according to PRAMS data, 91.4% of Maryland mothers reported having breastfed their babies. Rates of breastfeeding in Maryland were high across all races, ranging from 83.4% for non-Hispanic Black mothers to 98.3% among Asian mothers.[19]

Teen Pregnancy. Maryland VSA data shows that 2,134 births (3.2% of total births) in 2023 were to women under the age of 20. This percentage was more than doubled among Hispanic women (948 births, 6.6%). The lowest percentage was observed among non-Hispanic Asian or Pacific Islander women (9 births, 0.2%).

Insurance Coverage. Maryland is a Medicaid expansion state. In 2023, Maryland's uninsured rate was 6.3%, lower than the national rate of 7.9%. The uninsured rate in Maryland is highest for those who identify as American Indian and Alaska Native (24.8%), followed by those who identify as Hispanic or Latino. (22.5%). By age, the uninsured rate is highest for 26-34-year-olds (10.7%), followed closely by 35-44-year-olds (10.0%). According to the 2023 Maryland Behavioral Risk Factor Surveillance System (BRFSS), 89.0% of women ages 18—44 had health care coverage, and 77.7% of women ages 18-44 had a routine check-up in the past year.[20]

Statewide Initiatives that Support Maternal Health

Integrated Maternal Health Services Initiative (IMHS). Maryland currently utilizes two forms to refer high-risk individuals for care: the Maryland Prenatal Referral Assessment form (MPRA) and the Postpartum Infant Maternal Referral Form (PIMR). In 2023, the Maryland Department of Health Maternal and Child Health Bureau was awarded a HRSA-funded grant for its Integrated Maternal Health Services Initiative (IMHS). Maryland utilizes these funds to digitize and integrate these referral forms into the state's health information exchange, CRISP, and pilot them in select jurisdictions. As of April 2025, the electronic MPRA has been rolled out to 10 jurisdictions. In FY26, the state will roll out the digital PIMR form and will conduct assessments and technical assistance with participating jurisdictions.

Maryland Addiction Consultation Service (MACS for MOMs). MACS for MOMs is a program based at the University of Maryland, which provides support to providers and practices in addressing the needs of pregnant and postpartum patients with substance use disorder. Its primary activity is offering consultation services via a warmline staffed by

[19] Maryland Department of Health. Behavioral Risk Factor Surveillance System. https://health.maryland.gov/phpa/ccdpc/Reports/pages/brfss.aspx
[20] Maryland Department of Health. Behavioral Risk Factor Surveillance System. https://health.maryland.gov/phpa/ccdpc/Reports/pages/brfss.aspx

a behavioral health consultant or a formal consultation with a MACS clinician. It also offers numerous educational opportunities, such as training on prescription of medications for opioid use disorder, webinars on topics related to the care of patients with substance use disorder, and an ECHO Clinic, which offers synchronous online group learning sessions with expert clinician teams.

Maryland Maternal Health Innovation Program (MDMOM). Maryland is a member of the first cohort of nine states to receive funding through the Maternal Health Innovation Program Grant from the Health Resources and Services Administration (HRSA) in 2019. The program in Maryland, called MDMOM, aims to improve maternal health across the state by coordinating innovation in the areas of maternal health data, hospital and community service delivery, training, and resource availability. MDMOM is a collaboration between Johns Hopkins University, Maryland Department of Health, and the Maryland Patient Safety Center. In 2023, MDMOM was awarded an additional 5 years of grant funding to continue its activities and broaden its scope.

Maternal Health Improvement Task Force. The Maternal Health Improvement Task Force was established as part of the MDMOM Program in 2020. The Task Force meets quarterly at a central location within the State and brings together a multi-disciplinary group of key stakeholders, including officials from state health governing bodies, departments, and agencies; professional organizations; maternity health care providers; insurance payers; patient advocacy groups; and local community organizations. The Task Force is responsible for developing a statewide strategic plan for improving maternal health. Additional activities of the Task Force include member journal clubs, conceptualization of the Maryland Maternal Health Resource Map with subsequent development of the Map with the MDMOM Team and a 2 day strategic planning retreat.

Severe Maternal Morbidity (SMM) Surveillance and Review. MDMOM established Maryland as the first state in the U.S. to implement statewide surveillance of SMM following passage of the Maryland Maternal Health Act of 2024 (HB1051), which requires all birthing facilities in Maryland to participate in the facility-based SMM Surveillance & Review Program. SMM Surveillance and Review is coordinated by MDMOM and was first implemented in August 2020 as a pilot in six birthing facilities. Each subsequent year, additional facilities have voluntarily joined the program, with 27 facilities participating prior to the 2024 mandate.

The process for SMM Surveillance and Review in Maryland follows recommendations from the American College of Obstetricians and Gynecologists and the Society for Maternal and Fetal Medicine. The criteria used to identify SMM events include all hospitalized pregnant and up to 42-day postpartum patients who are: 1) admitted to the intensive care or critical care unit (ICU/CCU); and/or 2) receive transfusion of 4 or more units of blood products. Within each hospital, designated data abstractors identify cases that meet SMM criteria using the Electronic Health Record and enter requested information into a standardized electronic database. Abstracted SMM cases are reviewed at least quarterly by internal, multidisciplinary hospital-based review committees. Review committees assess each SMM event's preventability and draw lessons for practice reforms. MDMOM summarizes these findings in an annual statewide SMM Surveillance and Review report that is disseminated to hundreds of maternal health stakeholders via multiple maternal health improvement listservs.

Telehealth Initiative for Severe Hypertension in Pregnancy. MDMOM launched a telehealth initiative for severe hypertension during pregnancy in 2022. The initiative offers to all Maryland birthing hospitals distribution of free Bluetooth blood pressure monitors, cuffs, and education materials (How to Measure Your Blood Pressure + Urgent Maternal Warning Signs) to patients with or at risk of hypertension in pregnancy or postpartum for self-monitoring. Currently, the initiative is active in 29 of 32 birthing hospitals across the state with an average of 14 blood pressure monitoring units distributed to eligible patients every day. Each hospital has been enabled to develop institutional follow-up mechanisms and adapt the initiative to their setting.

Mothers and Babies. MDMOM is partnering with Northwestern University to train home visitors in an evidence-based program to help pregnant women and parents manage stress and prevent postpartum depression. This program, called Mothers and Babies, is based on principles of cognitive-behavioral therapy, attachment theory, and psychoeducation. It teaches strategies to help manage mood and stress within the context of parenting a baby, focusing on three specific areas: encouraging more engagement in pleasant activities, promoting healthier ways of thinking, and improving social support. The Mothers and Babies program can be delivered during individual one-on-one sessions, or it can be completed via an interactive, online program (eMB) with coaching support. MDMOM trained 59 home visitors as part of a first cohort in 2024 and will offer training to a second cohort in 2025.

Maryland Maternal Health Resource Map. The resource map was launched in March of 2024 in response to an identified need for a centralized resource list from the Maryland Maternal Health Improvement Task Force. The map includes 26 resource categories identified as priorities by stakeholders. While developing the tool, community

outreach was conducted to understand the target audience's needs and preferences. Subsequently, structured user-testing was conducted to assess usability and satisfaction with the map among a sample of potential users of the resource map, recruited in partnership with Baltimore Healthy Start. Following launch, two statewide advertisement campaigns have run to raise community awareness of the tool, utilizing a variety of advertising tactics including social media, transit, and micro-influencer advertisements. Printed posters and handouts have also been distributed to clinical settings. The website which houses the resource map, mdmomresources.org, has received over 165,000 views as of August 2025. Outreach and dissemination is ongoing, particularly efforts to encourage stakeholder engagement with the map contact form, ensuring the website is accurate and regularly updated.

Maryland Maternal, Infant, and Early Childhood Home Visiting. Early Childhood Home Visiting is a voluntary primary prevention strategy that improves maternal and child health outcomes, enhances parenting, and promotes the growth and development of young children. Home-visiting programs are focused on individualized, and culturally competent services for expectant parents, young children, and their families. These programs are made available in the home and help families strengthen attachment, foster optimal development for their children, promote health and safety, and reduce the risk of child maltreatment.

In 2010, the Affordable Care Act (ACA) established the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. Funds provided to states must be allocated to communities at highest risk, as identified through a comprehensive needs assessment, and these funds may only support evidence-based home-visiting programs that meet specific federal criteria. Currently, seven evidence-based home-visiting programs are in use in Maryland: Nurse-Family Partnership, Healthy Family America, Parents as Teachers, Home Instruction for Parents of Preschool Youngsters (HIPPY), Early Head Start, Healthy Start, Family Connects, and Attachment & Biobehavioral Catch-up (ABC). Additionally, longstanding locally developed home-visiting programs in Maryland such as Baltimore Healthy Start, and the Baltimore City Health Department Maternal and Infant home visiting program have demonstrated improved perinatal outcomes.

Maryland Perinatal-Neonatal Quality Collaborative (MDPQC). The MDPQC is a network of perinatal care providers and public health professionals working to improve health outcomes for women and newborns through continuous quality improvement. Periodically, the MDPQC selects a maternal health and neonatal health-focused initiative. The Collaborative provides participating birth hospitals with educational resources, technical assistance, and a platform for communication and sharing best practices.

All 32 birth hospitals in Maryland participate in the MDPQC. The current maternal health focus is obstetric hemorrhage, through implementation of the Alliance for Innovation on Maternal Health (AIM) patient safety bundle. The hemorrhage bundle components review Readiness through ensuring every unit is equipped with hemorrhage-specific supplies, protocols, and trained staff to respond effectively at any time; Recognition and Prevention through implementing standardized risk assessments and quantitative blood loss measurements to identify hemorrhage early in every patient; Response through establishing a stage-based, team-driven response plan with clear roles and access to necessary interventions and medications and prevention through standard protocol for measurement; Reporting and Systems Learning through using data-driven reviews and multidisciplinary debriefs to track outcomes, identify gaps, and continuously improve care systems; and Respectful Care through providing supportive and culturally responsive care that centers the patient's voice and dignity throughout the experience.

The MDPQC previously completed an initiative with all 32 Maryland birthing hospitals focusing on severe hypertension in pregnancy, which resulted in an increase in hospitals with updated policies for management of severe hypertension and preeclampsia, improved care

team education rates on hospital hypertension and preeclampsia protocols and measures, as well as a higher percentage of patients receiving timely treatment (within 60 minutes) following a sustained severe hypertensive episode. The MDPQC has supported hospitals in continuing to track and address select measures after bundle implementation ended in 2023.

Maternal Mortality Review (MMR) Team and the MMR Stakeholder Group. Since 2000, with the enactment of the Health-General Article, §13-1201 through §13-1207, Maryland has had a Maryland Maternal Mortality Review Team that identifies maternal death cases; reviews medical records and other relevant data; determines preventability of deaths; develops recommendations for the prevention of maternal deaths; and disseminates findings to policymakers, health care providers, health care facilities, and the public. The Maryland Maternal Mortality Review Team has served as a leader for other states that have developed their own Maternal Mortality Review Committees. Annual reports produced by the Maternal Mortality Review Program are available here.

In 2018, the Maryland General Assembly established a Maternal Mortality Review (MMR) Stakeholder Group with House Bill 1518 to review the findings and recommendations in the annual Maternal Mortality Review Report. The MMR Stakeholder Group is charged with examining issues resulting in maternal deaths, reviewing the status of implementation of previous recommendations, and identifying new recommendations with a focus on initiatives to address maternal deaths among groups with high MMR.

Maternal Opioid Misuse Model (MOM Model). The Maryland Department of Health launched its Maternal Opioid Misuse (MOM) model in January 2020, with funding from the Center for Medicare and Medicaid Innovation and in collaboration with the Centers for Medicare & Medicaid Services. Maryland's MOM model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with Opioid Use Disorder (OUD) through enhanced case management services, with an emphasis on increasing health service utilization, as well as screening and referral for non-medical drivers of health. MOM program services started on July 1, 2021 as a pilot in St. Mary's County, continuing for one year before expanding to select counties a year later. Starting January 1, 2023, the MOM program became available statewide, open to all eligible HealthChoice members. As of May 2025, the program has served over 140 participants.

Maryland Family Planning Program. The Maryland Family Planning Program improves maternal health by ensuring access to breast and cervical cancer screening, prevention and treatment of sexually transmitted infections, contraception, HIV testing and prevention education, infertility and preconception services, health education and counseling, and referrals to community resources. In May 2019, Maryland became the first state to formally withdraw from Title X federal funding for family planning services in the setting of new restrictions. At this time, Title V partnered with the Maryland Family Planning Program to continue to provide critical reproductive health services. There are more than 70 family planning clinical sites across the state. Services are free or low-cost and do not require insurance.

Maryland Patient Safety Center (MPSC). The MPSC was established by the Maryland Legislature in 2003 and first received designation as the state patient safety center by the Maryland Healthcare Commission in 2004. State re-designation has been continued by the Maryland Healthcare Commission since 2004 and is in effect through June 2027. The MPSC's mission is to unite stakeholders to champion patient safety, eliminate preventable harm, and accelerate improvements in safety to impact quality across healthcare. It serves patients, families, and the healthcare workforce by leveraging our collective expertise, advancing safety science, fostering system-wide learning, and empowering organizations to achieve meaningful, lasting outcomes. Though its focus is not limited to maternal health, MPSC conducts several maternal health programs.

B.I.R.T.H. Equity Maryland. B.I.R.T.H. Equity Maryland is a statewide initiative designed to advance maternal health by enhancing the knowledge, awareness, and responsiveness of non-obstetric healthcare providers, particularly those working in Emergency Departments and Primary Care. The program aims to reduce preventable maternal mortality and morbidity by equipping providers to recognize early warning signs of obstetric complications, apply effective teamwork and communication strategies, and address unrecognized contributors through training and guided reflection. The initiative also includes the distribution of patient and family education resources to promote awareness and self-advocacy around urgent maternal warning signs.

Launched in 2023, B.I.R.T.H. Equity was offered free of charge to Emergency Departments (EDs), primary care offices, and community organizations across the state. Seventeen sites enrolled—15 EDs and 2 primary care practices—forming three cohorts based on self-selected start dates in April and August 2023. The program was delivered through ReadyWorks Health, a confidential, device-agnostic digital platform, enabling flexible participation. Over 1,000 healthcare professionals have completed the program. The program was funded by grants from the France Merrick Foundation, The Maryland Hospital Association, and the Maryland Patient Safety Center.

Perinatal and Neonatal Quality and Safety Fellowship. The MPSC's Perinatal and Neonatal Quality and Safety Fellowship is a yearlong program designed to empower perinatal and neonatal professionals to develop, implement, evaluate, and sustain quality-improvement initiatives aimed at improving outcomes for perinatal patients. Fellows receive personalized mentorship and participate in monthly group meetings to identify key quality issues, refine QI methods, analyze data, and build lasting infrastructure within their organizations.

Count the Kicks. In Maryland, the Count the Kicks program—offered in partnership with the MPSC—provides free educational resources on fetal movement monitoring to hospitals, health departments, OB/GYN offices, and doula groups across the state. Since launching in 2023, more than 70,000 pieces of educational material have been ordered, including resources translated into Spanish and Haitian Creole, and eight organizations are currently enrolled in the Count the Kicks Implementation Partner Program to standardize the delivery of fetal movement education.

Perinatal Debriefing Initiative. Implemented in partnership with MDMOM, the Maryland Patient Safety Center's Perinatal Debriefing Initiative is an 18-month program that trains perinatal nurse and provider "champions" in structured debriefing after severe maternal or neonatal events, using a train-the-trainer model to establish standardized workflows and emotional support systems in participating birthing units. By combining gap analysis, focus groups, site-specific training, and ongoing implementation support, the initiative promotes both clinical quality improvement and staff well-being across Maryland hospitals.

Babies Born Healthy Program. The Babies Born Healthy (BBH) Program aims to improve infant health in Maryland by targeting infant mortality, specifically by narrowing the difference in outcomes between non-Hispanic Black and non-Hispanic white infants. In 2023, the infant mortality rate was 5.7 per 1,000 live births (a decrease from 6.2 in 2022). The rate was 9.0 among non-Hispanic Black individuals and 3.7 among non-Hispanic white individuals (4.8 among Hispanic individuals). BBH's program areas include perinatal care coordination, doula and community birth worker workforce development, and CenteringPregnancy® model group prenatal care. BBH perinatal care coordination focuses resources on the eight jurisdictions with the highest numbers and rates of infant deaths, which include Anne Arundel, Baltimore, Caroline, Charles, Montgomery, Prince George's, and Wicomico Counties along with Baltimore City.

Community Health Workers (CHWs) collaborate with nurses to target care coordination and navigation services in high-risk neighborhoods to link pregnant individuals to essential services that have been associated with improved birth outcomes. BBH also works in partnership with Maryland Medicaid to implement the Maryland Doula Training Hub, which facilitates recruitment, training, and reimbursement of community-based perinatal doulas. Lastly, between 2022 and 2025 BBH accessed funding from the Statewide Integrated Health Strategy (SIHS) to expand CenteringPregnancy® sites throughout the state. CenteringPregnancy® is an evidence-based group prenatal care model which supports cohorts of 8-10 pregnant women with similar gestational ages and other characteristics. It has been shown to reduce preterm birth and low birth weight, especially among communities at risk of perinatal complications and poor health outcomes.

Maryland Prenatal and Infant Care Coordination Services Grant Program Fund (Thrive by Three). The purpose of the Thrive by Three fund is to improve care coordination services for low-income pregnant and postpartum women and children from birth to 3 years of age. Any local jurisdiction in the State of Maryland is eligible to apply for the Thrive by Three program. Priority is given to proposals from a county or municipality that has: a high number of births to women enrolled in Medicaid; has high rates of infant mortality; has high rates of preterm birth; and can demonstrate that the program will be coordinated with community-based service providers. During the 2021 Maryland General Assembly Session, Senate Bill 777 was passed,

which expanded the program to allow direct granting of funds to federally qualified health centers (FQHCs), hospitals, and other providers of prenatal care. Repeat grantees of the Thrive by Three Fund include the Harford County Health Department, which provides care coordination through MEGAN's Place and the St. Mary's County Health Department, which provides care coordination to refugee and undocumented birthing families.

Perinatal System Standards of Care for Maryland Birthing Hospitals. The Maryland Perinatal System Standards were developed in the mid-1990s by a Maryland Department of Health advisory committee as a set of voluntary standards for Maryland hospitals providing obstetric and neonatal services. Level III and Level IV hospitals are designated perinatal referral centers that provide specialized care for both pregnant women, as well as neonates.

The Standards have since been incorporated into the regulations for designation of perinatal referral centers by the Maryland Institute for Emergency Medical Services Systems (MIEMSS), as well as the Maryland Health Care Commission's State Plan regulations for obstetrical units and neonatal intensive care units. MIEMSS regulates Level III and Level IV Hospitals. Level I and Level II are voluntary designations as delivery hospitals but do not have the same specialized care as Level III and Level IV hospitals. Maryland Department of Health reviews and monitors the voluntary designation of Level I and II hospitals as authorized by Health-General Article, §18-107, Annotated Code of Maryland and outlined in COMAR 10.11.06.00-13.

Statewide Integrated Health Improvement Strategy (SIHIS). By agreement with the Centers for Medicare and Medicaid Innovation (CMMI), Maryland has a unique all-payer hospital financing structure directed and managed by the Maryland Health Services Cost Review Commission. By agreement with CMMI, the State adopted a Statewide Integrated Health Improvement Strategy (SIHIS) between December 2020 and December 2025, to advance hospital care quality, care transformation across the health care system, and population health. The last goal, total population health, has three domains: diabetes, opioids, and maternal and child health.

The maternal health goal is focused on the reduction of severe maternal morbidity (SMM). Specifically, SIHIS outlines that the goal is to reduce the severe maternal morbidity rate overall from 242.5 SMM events per 10,000 delivery hospitalizations (2018) to 197.1 SMM events per 10,000 delivery hospitalizations (2026). The excess rate of Black non-Hispanic SMM events (compared to White non-Hispanic SMM events) is targeted to be reduced by 25% by 2026. SIHIS maternal health activities include efforts to increase group-based prenatal care through the Centering Pregnancy® approach, increase linkages to care for pregnant women with opioid use disorder, doula services reimbursement through Medicaid, and an expansion of evidence-based and promising practice maternal and infant home- visiting services.

Title V Maternal and Child Health Services (MCH) Block Grant. The Title V MCH Block Grant provides funds to states to improve the health of women and children, including those with special health care needs. The program is authorized under Title V of the 1935 Social Security Act and is administered by the Maternal and Child Health Bureau of the HRSA of the U.S. Department of Health and Human Services. At the state level in Maryland, the grant is administered by the Prevention and Health Promotion Administration (PHPA) of the Maryland Department of Health.

As health care has continued to undergo payment reforms, Title V continues to collaborate with the Medicaid Program to improve access to health care services for women and children. As more eligible residents have received Medicaid coverage to enable them to access health care, Title V has shifted its emphasis from a direct service gap-filling model to more of a population and infrastructure-based model.

Maryland Title V has supported activities to address national maternal health performance measures such as low-risk cesarean delivery, breastfeeding, preventive dental care, and smoking during pregnancy. These activities have included providing essential care coordination and home-visiting services through local health departments and community-based organizations, leading collaborations on quality improvement with birthing hospitals through the Perinatal Neonatal Quality Collaborative, and conducting essential public health infrastructure activities such as epidemiology, project management and administration, and surveillance support. In addition, Title V funds support surveillance and quality improvement activities including Fetal and Infant Mortality Reviews, Child Fatality Reviews, and Maternal Mortality Reviews. These reviews identify clinical, non-clinical, and system factors that contribute to adverse outcomes.

Women's Health Action Plan. The MDH Women's Health Action Plan aims to improve physical, mental and emotional well-being and ensure reproductive and sexual health autonomy over the life course. It is intended to build upon the existing workplan of MDH and other statewide initiatives, like SIHIS and MDMOM, and includes the following six key goals: 1) protect reproductive rights and expand access to reproductive health services 2) advance maternal and infant health through the perinatal continuum; 3) support behavioral health needs across the life course; 4) improve access to comprehensive high-quality somatic services through the life course; 5) increase place-based and community-centered approaches to promote health and prevent diseases; and 6) expand, support and diversify the perinatal workforce.

Local Initiatives that Support Maternal Health

Maryland Community Health Resources Commission (CHRC). The Maryland CHRC supports grantees to deliver services to medically underserved women in several jurisdictions throughout Maryland. In 2024, the CHRC awarded three grants as part of its program area to promote comprehensive women's health services and reduce infant mortality.

In Baltimore City, the CRCC provided resources to Baltimore Medical System, Inc. to expand the CenteringPregnancy® program at a clinic that serves a community with high needs related to social drivers of health. The Prince George's Child Resource Center, Inc. received a grant from the CHRC to expand the Family Connects Prince George's program, which provides home visits within one month of delivery hospitalization discharge. These visits serve to connect families to primary and postpartum care and facilitate ongoing home visiting services. In northern Anne Arundel County and southern Baltimore City, the University of Maryland Baltimore Washington Medical Center received a grant to improve birth outcomes by connecting women to registered dieticians, pilot the RXFood app, and provide meals through Moveable Feast.

Balimore City's Coordinated Maternal and Infant Health Improvement Strategy. B'more for Healthy Babies (BHB) is Baltimore City's strategy to prevent infant mortality and improve maternal and child health outcomes at a population level. Since the launch of BHB in 2009, the city's infant mortality rate has decreased by 35%, and the Black-White difference in infant mortality has decreased by 53%. BHB works citywide as well as intensively in two communities, Upton/Druid Heights and Patterson Park North & East, to improve maternal health. Intervention begins in adolescence with BHB's

Youth Sexual Health Initiative and its U Choose campaign to provide reproductive health education in city schools and help young adults make informed choices about health and family planning. In pregnancy and postpartum, BHB's centralized intake system provides care coordination that links thousands of mothers to prenatal, specialty, and behavioral health care and community supports needed to have a healthy pregnancy, such as home visiting and nutrition support. In the two BHB communities, group-based programs like prenatal Moms Clubs and breastfeeding support groups help mothers create social connections while supporting their health. In Upton/Druid Heights, the B'more Peaceful Motherhood program screens mothers for high blood pressure and provides support for mindfulness and stress reduction, and in Patterson Park North & East, the nutrition and fitness group B'more Fit gives mothers free opportunities to exercise and make friends. The combination of building citywide infrastructure to support maternal health and offering local intensive support based on the needs of mothers in the community is critical to BHB's success.

New Policies that Support Maternal Health

The Maryland Maternal Health Act of 2024 (HB 1051/SB1059) established several requirements for health departments, healthcare providers, and healthcare facilities to improve maternal health and health care. It includes four focus areas: Maryland Prenatal Risk Assessment, high-risk pregnancy, Report Card for Birthing Facility Maternity Care, and Severe Maternal Morbidity surveillance and review.

Maryland Prenatal Risk Assessment (MPRA). The law requires prenatal providers to complete an MPRA and send it to their local health department (LHD) for all Medicaid-insured patients at their first prenatal visit. It also requires LHDs to submit an annual report to MDH on the number and type of referrals resulting from MPRAs and MDH to develop a digital MPRA. The MPRA stipulations are part of the Integrated Maternal Health Services Initiative, which seeks to connect women to community-based services that address social drivers of health through coordination with prenatal providers and birthing hospitals. The initiative will begin with Prince George's County and the Eastern Shore and expand to the Baltimore Metro region after two years.

High-Risk Pregnancy. The law stipulates that following the delivery of a high-risk pregnancy, the birthing hospitals must complete a Postpartum Infant and Maternal Referral (PIMR) form and send it to the LHD of the patient's home jurisdiction. The hospital must also provide resources and information specific to the patient's condition (e.g., cardiovascular conditions, chronic diseases, substance misuse, and mental health conditions), including risks, warning signs, preventative measures, and treatment needs, and call the parent within 48 hours to evaluate their condition.

Report Card for Birthing Facility Maternity Care. The law requires MDH to publish an annual report card on birthing facility maternity care in collaboration with the Maryland Health Care Commission (MHCC). The report cards will include rates of vaginal and cesarean delivery; rates of maternal complications, including hemorrhage, laceration, and infection; qualitative data regarding patient perception of respectful maternity care; and a score that is balanced by the risks associated with the level of acuity of patients served. All data in the report card will be disaggregated by race and age, and

the included criteria will be reviewed and updated every three years. In addition to the Maternal and Child Health Bureau and MHCC, the MDH data office, the Chesapeake Region Information System for Patients (CRISP) and the Health Services Cost Review Commission (HSCRC) are collaborating to develop the report card. In addition to the aforementioned criteria, the report card will report on structural measures including health professional completion of education on respectful care, unit safety drills, and the availability of patient education materials on urgent postpartum warning signs.

Severe Maternal Morbidity (SMM) Surveillance and Review. The law requires all birthing facilities to participate in MDMOM's SMM Surveillance and Review Program. It also requires the SMM Surveillance and Review Program to submit a a first statewide report to the governor by December 1, 2025.

The Giving Infants a Future Without Transmission (GIFT) Act. The GIFT Act (HB0119/ SB2011) was passed, in part, in response to rising congenital and acquired syphilis rates in Maryland. It also addresses vertical transmission of HIV. Syphilis testing will be required at the first prenatal visit, 28 weeks of gestation, and birth; patients will not be able to discharge infants if maternal syphilis serology is unknown. It also requires syphilis testing for stillborn infants greater than or equal to 20 weeks of gestation or 500g. Regarding HIV, new diagnosis reports must include pregnancy status, and births to HIV positive mothers must also be reported. HIV testing will be required at birth, and infants will be tested if maternal HIV status is unknown.

Maternal Health Self-Measured Blood Pressure Monitoring. The Maryland Medical Assistance Program - Maternal Health Self-Measured Blood Pressure Monitoring Act (HB553/ SB094) requires the Maryland Medical Assistance Program to provide coverage for self-measured blood pressure monitoring and reimbursement of health care provider and other staff time used for patient training, transmission of blood pressure data, interpretation of blood pressure readings and reporting, remote patient monitoring, and the delivery of co-interventions, including educational materials or classes. The Act was passed in 2025 and will take effect January 1, 2026.

Maternal Health Improvement Task Force

The Maternal Health Improvement Task Force aims to:

- Coordinate activities and programs that aim to improve the health and well-being of pregnant and postpartum women in the state of Maryland;
- Identify state-specific gaps in the following areas: maternal health data, delivery of an access to quality perinatal health care services, and relevant laws and health policies for pregnant and postpartum women;
- Develop a 5-year Strategic Plan to improve maternal health in Maryland, building on the 2025 Maryland Title V Needs Assessment, work plans of ongoing maternal health programs in the state, and available maternal health case review and population-level surveillance data;
- Engage, support, and monitor implementation of maternal health programs in Maryland;
- Assist with dissemination of maternal health program evaluation findings and lessons learned in Maryland and beyond;
- Develop a Sustainability Plan to ensure continuity of work toward improving maternal health in the State of Maryland.

Task Force Vision and Mission

Vision: All families in Maryland are in optimal health and thriving before, during and after pregnancy.

Mission: The Maryland Maternal Health Improvement Taskforce identifies and supports effective policies and initiatives that improve access to services and enhance the quality of comprehensive reproductive, perinatal, and postpartum care in an effort to reduce the rates of maternal morbidity and mortality.

Task Force Values and Guiding Principles

- **Consistency.** Operate with integrity to implement consistent policies and practices.
- **Holistic Approach.** Understand the impact of environmental conditions and lived experiences on an individual's health and well-being.
- **Respect.** Honor and respect all families.
- **Strengths Based.** Focus on family and community strengths in all programs, policies, and procedures to create positive outcomes.
- **Sustained Community Networks.** Build partnerships through collaboration with community–based organizations.

Task Force Membership

Task Force members comprise representatives from local and state agencies, health care systems, payers, community groups and organizations serving families in the perinatal period,

professional organizations, and educational institutions, as well as patient representatives. Currently, over 30 members serve on the Task Force. Task Force meetings are held quarterly with ad-hoc meetings scheduled, as needed. See **Appendix 1** for a list of members and respective organizations serving on the Maryland Maternal Health Improvement Task Force.

Development of the Maternal Health Strategic Plan

To develop the 2025 Maternal Health Strategic Plan, the following steps were taken: 1) Review progress of previous strategies from the 2021 Maternal Health Strategic plan, 2) Conduct an environmental scan to understand opportunities and threat, 3) Facilitate discussion among members of the Task Force and other community members to understand the future state in 2030, 4) Identify of key priorities, goals, and desired outcomes based on identified strengths and challenges as well as from findings from the Title V MCH Needs Assessment; 5) Solicit stakeholder and public input; 6) Integrate feedback, revise and finalize the report.

Members of the Maternal Health Improvement Task Force led the development of this updated Maternal Health Strategic Plan. Stakeholder input sessions, including a day-long retreat, were held to conduct the environmental scan, visioning of maternal health in Maryland, and to identify key priorities, goals, and desired outcomes. See **Appendix 1** for a list of Task Force members.

Framework Informing the Maternal Health Strategic Plan

A Multi-Level Life Course Framework[21] guides the conceptualization of the strategic plan. This framework integrates two broad factors that lead to health outcomes: a person's life course and a person's exposure to their environment. Evidence for this approach comes from two models:

> **Life Course Model,** which recognizes the origins of differences in health outcomes: 1) through biological and behavioral mechanisms by which structurally patterned exposures during critical and sensitive periods of the life course, (e.g., the prenatal, postpartum, and early childhood periods), result in sustained shifts in health trajectories that may endure despite later intervention; and 2) through "weathering;" i.e., the hypothesis that

[21] Johns Hopkins Bloomberg School of Public Health. Life Course Framework and Areas of Interest. https://publichealth.jhu.edu/departments/ population-family-and-reproductive-health/research-and-practice/life-course-framework-and-areas-of-interest. Accessed August 18, 2025.

cumulative and stress-mediated wear and tear on a cellular integrity leads to accelerated biological aging, the premature dysregulation or exhaustion of important body systems, and the early onset of chronic diseases of aging, health-induced disability, and excess mortality among marginalized groups.[22]

Social-Ecological Model, which considers the impact of and interplay between individual factors (biological and behavioral), relationships (family, friends, social networks), community factors (neighborhoods, workplaces, schools) and societal factors (cultural norms, government policies) on health and health outcomes, and suggests that these factors play critical roles in shaping health.[23]

Application of the Multi-Level Life Course Framework helps to uncover and illuminate the mechanisms that lead to differences in health outcomes and identifies courses of action to achieve physical, emotional, and social health and well-being.[24]

[22] Jones, NL, Gilman SE, Cheng TL, Drury SS, hill CV, Geronimus AT. Life Course Approaches to the Cause of Health Disparities.Am J Public Health. 2019;109(S1):S48-55.
[23] U.S. Centers for Disease Control and Prevention. The Social-Ecological Model: A Framework for Prevention. https://www.cdc.gov/violence-prevention/about/index.html. Accessed August 18, 2025.
[24] Peterson A, Charles V, Yeung D, Coyle K. The Health Equity Framework: A Science- and Justice-Based Model for Public Health Researchers and Practitioners. Health Promotion Practice. 2020;22(6):741-6.

Task Force Priorities

As part of the strategic planning process, the Task Force identified the following priorities for maternal health in Maryland:

- Increase access to high-quality, consistent perinatal care
- Ensure access to mental and behavioral health specialties
- Address increasing trend in substance use overdose deaths
- Increase social support and opportunity for perinatal health education among pregnant and postpartum women, their support networks, and health care providers
- Support the creation of a multifaceted, holistic birth workforce.
- Address lack of funding for maternal health services and perinatal insurance coverage
- Improve data analysis and and timely dissemination of maternal health trends data
- Sustain networks and increase collaborations among maternal health stakeholders
- Consistency and availability of care
- Address morbidity and mortality of mothers and infants

ACTION PLAN FOR ADDRESSING MATERNAL HEALTH NEEDS

The Task Force organized the strategic plan for maternal health improvement around four priority goals. Each goal has two to five corresponding objectives.

- **Goal 1:** Prevent complications of pregnancy.
- **Goal 2:** Improve maternal mental/behavioral health through enhanced screening, diagnosis, and treatment.
- **Goal 3:** Support pregnant and postpartum women and their families by connecting them with comprehensive services.
- **Goal 4:** Improve the ongoing collection and utilization of maternal health data.

Vision: All families in Maryland are in optimal health and thriving before, during and after pregnancy.

Mission: The Maryland Maternal Health Improvement Taskforce identifies and supports effective policies and initiatives that improve access to services and enhance the quality of comprehensive reproductive, perinatal, and postpartum care in an effort to reduce the rates of maternal morbidity and mortality.

Goal 1: Prevent complications of pregnancy.

Obj 1.a. Increase the proportion of pregnant women who receive comprehensive postpartum care by 12 weeks following delivery.

Obj 1.b: Ensure standardized maternal urgent warning signs education is incorporated into the perinatal care continuum so that all pregnant women, their families/support networks, healthcare providers, and clinical support staff are exposed to the information.

Obj 1.c: All hospitals will use evidence-based and comprehensive prevention strategies to lower severe maternal morbidity.

Obj 1.d: Improve prevention, diagnosis, and treatment of hypertension across the perinatal continuum.

Obj. 1.e: Improve prevention, diagnosis, and treatment of diabetes and reduce obesity in preconception women.

Goal 2: Improve maternal mental/behavioral health through enhanced screening, diagnosis, and treatment.

Obj. 2.a: Enhance screenings (i.e., SBIRT), counseling, and medical and non-medical therapies for behavioral health conditions, including substance use disorders, depression, and anxiety.

Obj. 2.b: Train the perinatal work force to provide mental and behavioral health support to pregnant and postpartum postpartum women and their families

Goal 3: Support pregnant and postpartum women and their families by connecting them with comprehensive services.

Obj. 3.a: Increase pregnancy and postpartum referrals and connections to services.

Obj. 3.b: Increase enrollment in evidence-based and promising practice home visiting programs that provide comprehensive case management.

Goal 4: Improve the ongoing collection and utilization of maternal health data.

Obj. 4.a: Annually evaluate the causes of maternal mortality (MMRT) and severe maternal morbidity in Maryland through analysis of surveillance data and facility-based case reviews with a focus on risk factors and underlying causes.

Obj. 4.b: Enhance maternal health surveillance and quality initiatives through the collection of qualitative data that captures the perspectives of mothers.

Obj. 4.c: Disseminate maternal health data using a centralized state-wide maternal health data reporting tool.

Tactics, Partners, and Metrics

To make the strategic plan actionable, tactics, partners, and metrics are outlined in **Appendix 2.** Each objective has one to four tactics, i.e., time specified action steps that will be taken to accomplish the objective. A lead partner and other key partners are identified to collaborate, carryout, and support each objective. Finally, metrics are assigned to each objective as a benchmark for evaluating progress.

Sustainability

In addition to supporting and monitoring the implementation of the strategic plan, the Maryland Maternal Health Improvement Task Force is committed to developing a *Sustainability Plan* (see Task Force purpose above) to ensure continuity of work toward improving maternal health in Maryland. Work on a sustainability plan will span the five years of the strategic plan (2025-2030). The goal is to sustain effective maternal health programs and initiatives in Maryland. Accomplishing this goal will require contributions from all Task Force members, in addition to the identification of new partners and sources of funding, both public and private.

Appendix 1. Maryland Maternal Health Improvement Task Force Members

Name	Organization
Donna Neale, MD, Chair	**University of Maryland School of Medicine**
Erin Anderson, RN,MS	Howard County Health Department
Lauren Arrington, CNM	University of Maryland St. Joseph Medical Center
Tope Bada, MD	Anne Arundel County Health Department
Kelly Bower, PhD, RN	Johns Hopkins University School of Nursing
Kristen Brooks, LCSW-C, LICSW, PMH-C	Building Beyond Therapy
Adriane Burgess, PhD, RNC-OB	Maryland Patient Safety Center
Stephanie Burke, MS,MHA	Prince George's Community College
Elizabeth Chung	Asian-American Center for Frederick
Rebecca Dineen, MS	Baltimore City Healthy Department
Tracey DeShields, JD,LLM	Maryland Health Care Commission - Government Affairs and Special Projects
Jackie Douge, MD, MPH	Hood College
Danielle Haskin, MSPH	Frederick County Health Department
Alyson Jacobson, MSW	Prince George's Child Resource Center
Clark Johnson, MD	Maryland ACOG
Tianna Leon, MPH	Health Resources and Services Administration
Kerry Lewis, MD	University of Maryland Capital Region Health Medical Center
Charnise Littles, IBCLC	Birth and Milk Co
David Mann MD, PhD	Maryland Department of Health
Shawn McIntosh	Maryland State Medical Society (MedChi)
Ashley Milcetic	St. Mary's County Health Department
Kristen Newmann, DrPH, MPH, RN	Prince George's County Health Department
Laurence Polsky, MD	Calvert County Health Department
Maxine Reed-Vance, RN	Baltimore Healthy Start
Katie Richards, MPH	Health Quality Innovators
Erika Seth Daviez	Rhia Ventures
Jeanne Sheffield, MD	Johns Hopkins University
Jamie Swietlikowsk	Maryland Affiliate of the American College of Nurse Midwives
Denys Symonette Mitchell, MSW	Symonette Strategies and Solutions LLC.
Lisa Wright, MA	Johns Hopkins University
Nina Martin, MSPH	Maryland Department of Health

Appendix 2. Maryland Maternal Health Improvement Action Plan

GOAL 1: PREVENT COMPLICATIONS OF PREGNANCY.

	Lead & Key Partners*^	Key Metrics
Objective 1.a: Increase the proportion of pregnant women who receive comprehensive postpartum care by 12 weeks following delivery.		
Tactic 1.a.1: Convene a meeting with lead and key partners to develop a strategy and workplan that identifies key interventions to ensure all women receive two postpartum visits within 12 weeks after deliver. [Timeline: 2025-2026]	**Lead:** MHITF **Partners:** MDPQC, FQHCs, local health departments and home visiting programs, birthing hospitals, neonatal and perinatal providers, MIECHV, MDH, community-based organizations	**Metric:** Percent of women who attend a postpartum checkup within 12 weeks after giving birth. [Source: PRAMS]
Objective 1.b: Ensure standardized maternal urgent warning signs education is incorporated into the perinatal care continuum so that all pregnant women, their families/support networks, healthcare providers, and clinical support staff are exposed to the information.		
Tactic 1.b.1: Distribute urgent maternal warning signs educational materials to hospitals, home visiting programs, and other programs serving pregnant and postpartum families (e.g., WIC). [Timeline: 2025-2028] **Tactic 1.b.2:** Conduct training of emergency department staff to identify urgent maternal warning signs. [Timeline: 2025-2028]	**Lead 1.b.1:** MDMOM **Lead 1.b.2:** MPSC **Partners:** Local health departments and home visiting programs, WIC, MDPQC, FQHCs, birthing hospitals, MIECHV, MDH, community-based organizations, perinatal, pediatric, primary, and emergency care providers	**Metrics:** Number and source of request for materials; number of posters, handouts, and magnets distributed. [Source: MDMOM]
Objective 1.c: All hospitals will use evidence-based and comprehensive prevention strategies to lower severe maternal morbidity.		
Tactic 1.c.1: Hospital implementation of AIM patient safety bundles including completion of the OB hemorrhage bundle with transition to sustainability planning by June 2026. **Tactic 1.c.2:** Make an informed selection of the next statewide perinatal safety initiative using maternal health data and stakeholder feedback by July 2026.	**Lead:** MDPQC **Partners:** MDH, MHITF, birthing hospitals	**Metric:** All Maryland hospitals actively participate in perinatal safety and quality initiatives. [Source: MDPQC]

Objective 1.d: Improve prevention, diagnosis, and treatment of hypertension across the perinatal continuum.		
Tactic 1.d.1: Distribute free blood pressure cuffs to all patients with hypertensive disorders of pregnancy (HDP) during prenatal care or before postpartum discharge. [Timeline: 2025-2030] **Tactic 1.d.2:** Facilitate co-learning among birthing hospitals with standardized postpartum HDP care plans, including early postpartum follow-up care. [Timeline: 2025-2026] **Tactic 1.d.3:** Monitor and report data annually on timely diagnosis and treatment of hypertension. [Timeline: 2025-2030]	**Lead 1.d.1:** MDMOM & Maryland Medicaid Managed Care Organizations (MCOs) **Lead 1.d.2:** MDPQC **Lead 1.d.3:** MDPQC **Partners:** MHITF, birthing hospitals, perinatal care providers, MPSC, MDPQC, BHB, Maryland Medicaid, Maryland MFPP, MIECHV, MDH, WIC, private health insurers, community-based organizations	**Metrics:** Number of blood pressure cuffs distributed by MDMOM annually. [Source: MDMOM] Number of individuals scheduled for postpartum follow up within 7 days. [Source: MDPQC] Percent of patients with severe hypertension receiving treatment within one hour. [Source: MDPQC]
Objective 1.e: Improve prevention, diagnosis, and treatment of diabetes and reduce obesity in preconception women.		
Tactic 1.e.1: Establish partnerships with stakeholders to increase awareness and education. [Timeline: 2025-2026] **Tactic 1.e.2:** Create a maternal health roadmap with a focus on preconception health, including diabetes and obesity. [Timeline: 2027]	**Lead:** MHITF **Partners:** Local health departments programs, school-based health centers, WIC, MFPP, YMCA, Maryland Recreation Parks and Planning, community-based organizations, perinatal, primary, OB/GYN, and pediatric providers	**Metric:** Roadmap is created. [Source: MHITF]

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GOAL 2: IMPROVE MATERNAL MENTAL/BEHAVIORAL HEALTH THROUGH ENHANCED SCREENING, DIAGNOSIS, AND TREATMENT.

	Lead & Key Partners*^	Key Metrics
Objective 2.a: Enhance screenings (i.e., SBIRT), counseling, and medical and non-medical therapies for behavioral health conditions, including substance use disorders, depression, and anxiety.		
Tactic 2.a.1: Host a consultation service warmline for providers to ask questions and access resources and referral information for supporting pregnant patients with a substance use disorder. [Timeline: 2025-2028] **Tactic 2.a.2:** Conduct provider training on prescribing and managing patients on medications for the treatment of opioid use disorders and Extension for Community Healthcare Outcomes (ECHO) sessions on related topics. [Timeline: 2025-2028] **Tactic 2.a.3:** Provide case management services to pregnant women on Medicaid with opioid use disorder. [Timeline: 2025-2028]	**Lead 2.a.1&2:** MACS for MOMs **Lead 2.a.3:** Maryland Medicaid **Partners:** MIECHV, MFPP, Medicaid MCOs, perinatal care providers, substance use disorder treatment clinics	**Metric:** Number of MACs for MOMs program participants and services provided. Percent of training participants who report it informed their clinical practice [Source: MDH]
Objective 2.b: Train the perinatal work force to provide mental and behavioral health support to pregnant and postpartum women and their families.		
Tactic 2.b.1: Provide training and disseminate the Mothers and Babies depression prevention program delivered by maternal, infant, and early childhood home visitors. [Timeline: 2025-2026] **Tactic 2.b.2:** Conduct and disseminate findings from a needs assessment that identifies barriers to accessing perinatal mood and anxiety disorder treatment. [Timeline: 2026] **Tactic 2.b.3:** Implement a statewide Perinatal Mental Health Training Hub to support perinatal mental and behavioral health workforce development and increase linkages to care for pregnant and postpartum women. [Timeline: 2027-2028] **Tactic 2.b.4:** Expand utilization of existing resources and materials already developed (e.g.,988 and the Maryland Maternal Health Resource Map). [Timeline: 2025-2030]	**Lead 2.b.1:** MDMOM **Lead 2.b.2:** MDH, MHITF **Lead 2.b.3:** MDH **Lead 2.b.4:** MHITF **Partners:** MIECHV, MACS for MOMs, Maryland Medicaid, local health departments and home visiting programs, perinatal providers, community-based organizations	**Metrics:** Number of home visiting programs and staff trained to deliver the Mothers and Babies intervention. [Source: MDMOM] Needs assessment findings presented to the MHITF. [Source: MDH] Number of Training Hub participants who completed all requirements to achieve the PMH-C credential. [Source: MDH]

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GOAL 3: SUPPORT PREGNANT AND POSTPARTUM WOMEN AND THEIR FAMILIES BY CONNECTING THEM WITH COMPREHENSIVE SERVICES.

	Lead & Key Partners*^	Key Metrics
Objective 3.a: Increase pregnancy and postpartum referrals and connections to services.		
Tactic 3.a.1: Expand use of the Maryland Prenatal Risk Assessment (MPRA) and the Postpartum Infant and Maternal Referral Form (PIMR), and ensure connections are made based on those referrals. [Timeline: 2025-2028] **Tactic 3.a.2:** Improve awareness of the Maternal Health Resource Map to pregnant and postpartum postpartum women and their families and care providers. [Timeline: 2025-2028] **Tactic 3.a.3:** Strengthen referral pathways from perinatal providers to community-based lactation supports. [Timeline: 2025-2028]	**Lead 3.a.1&3:** MDH **Lead 3.a.2:** MDMOM **Partners:** MIECHV, MFPP, FQHCs. BHS, Thrive by Three, Centering Pregnancy®, WIC, BHB, Maryland Medicaid, MDQPC, MHITF, birthing hospitals, local health departments and home visiting programs, perinatal, primary care, and pediatric providers	**Metrics:** Number of pregnant or postpartum individuals receiving a standardized risk assessment (MPRA and/or PIMR), total and by insurance type. And the number referred for breastfeeding/lactation services. [Source: MDH IMHS] Number of unique views of the Maternal Health Resource Map site & Maternal Health Report Card [Source: MDMOM & MDH]
Objective 3.b: Increase enrollment in evidence-based and promising practice home visiting programs that provide comprehensive case management.		
Tactic 3.b.1: Survey home visiting programs for services offered that are evidenced based. [Timeline: 2025-2030] **Tactic 3. b.2:** Connect home visiting programs to collaborate and share resources and establish benchmarks. [Timeline: 2025-2030] **Tactic 3.b.3:** Expand the MIECHV program to 24 jurisdictions (pending funding availability and interest). [Timeline: 2025-2030] **Tactic 3.b.4:** Promote the use of community health workers and home-visiting staff to screen patients for comprehensive services connecting this screening to reliable and effective local interventions. [Timeline: 2025-2030]	**Lead:** MIECHV **Partners:** Local health departments and home visiting programs, community-based organizations	**Metric:** Number of new and continuing enrollees by category (pregnant caregivers, other adult caregivers, target children), overall and by race/ethnicity. [Source: MDH] Percent of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery. [Source: MDH] Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally). [Source: MDH]

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GOAL 4: IMPROVE THE ONGOING COLLECTION AND UTILIZATION OF MATERNAL HEALTH DATA

	Lead & Key Partners*^	Key Metrics
Objective 4.a: Annually evaluate the causes of maternal mortality (MMRT) and severe maternal morbidity in Maryland through analysis of surveillance data and facility-based case reviews with a focus on risk factors and underlying causes.		
Tactic 4.a.1: Assimilate data from annual report card of birthing hospitals, the Maternal Mortality Review Program, and the SMM Surveillance and Review Program [Timeline: 2026]. **Tactic 4.a.2:** Analyze data and present the information to the Task Force. [Timeline: 2027] **Tactic 4.a.3:** Conduct reviews of pregnancy-associated deaths through the Maternal Mortality Review Program and present annual reports. [Timeline: 2025-2030]	**Lead:** MDH **Partners:** MDMOM, birthing hospitals, MDPQC, MHITF	**Metrics:** All birthing hospitals participate in SMM Surveillance Review Program by reporting SMM case data. [Source: MDMOM] Maternal Health Hospital Report Card presents information on key indicators by hospitals and is updated annually. [Source: MDH]
Objective 4.b: Enhance maternal health surveillance and quality initiatives through the collection of qualitative data that captures the perspectives of mothers.		
Tactic 4.b.1: Conduct interviews with patients and/or close contacts through the SMM Surveillance and Review Program and the Maternal Mortality Review Program. [Timeline: 2025-2028] **Tactic 4.b.2:** Enhance programmatic reporting among programs that serve Maryland families to better capture qualitative stories and perspectives. [Timeline: 2025-2030] **Tactic 4.b.3:** Elevate significant findings to the provider level to improve service delivery. [Timeline: 2025-2030]	**Lead 4.b.1:** MDMOM & MDH **Lead 4.b.2&3:** MDH **Partners:** MIECHV, MFPP, MHITF, Baltimore Healthy Start, MDPQC, local health departments, birthing hospitals, community-based organizations	**Lead 4.b.1:** MDMOM & MDH **Lead 4.b.2&3:** MDH **Partners:** MIECHV, MFPP, MHITF, Baltimore Healthy Start, MDPQC, local health departments, birthing hospitals, community-based organizations
Objective 4.c: Disseminate maternal health data using a centralized state-wide maternal health data reporting tool.		
Tactic 4.c.1: Launch the Maternal Health Hospital Report Card in July 2025, to be updated at least once every three years. [Timeline: 2025-2030] **Tactic 4.c.2:** Publish an annual report on the findings from the SMM Surveillance and Review Program. [Timeline: 2025-2028]	**Lead 4.c.1:** MDH **Lead 4.c.2:** MDMOM **Partners:** MHITF, birthing hospitals	**Metrics:** Centralized state-wide maternal health data reporting tool created and made publicly available. [Source: MDH] Report on SMM Surveillance and Review Program findings published annually. [Source: MDMOM]

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