



**SB 348**

**Hospitals and Freestanding Birthing Centers – High-Risk Pregnancies - Communication After Discharge  
WRITTEN TESTIMONY BEFORE THE SENATE FINANCE COMMITTEE**

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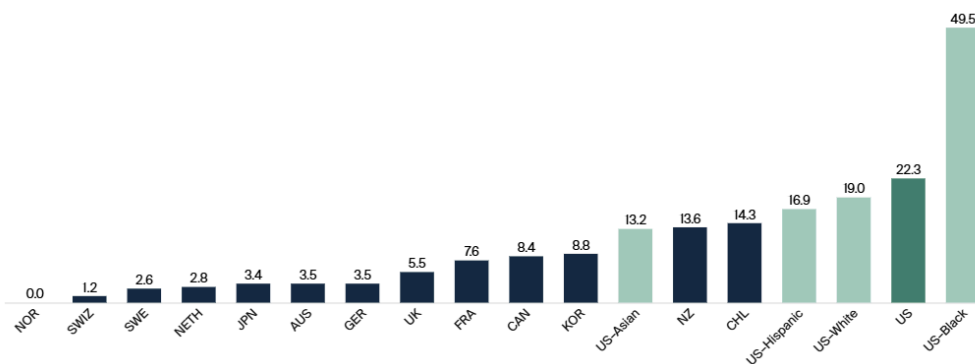
*Position: Oppose – Date: February 10, 2026*

The Maryland Association of County Health Officers (MACHO) opposes SB 348 out of concern that the proposed changes will weaken protection of maternal health. Current statute requires hospitals and birthing centers to contact **high-risk** postpartum patients 24-48 hours after discharge to assess for developing serious health problems. 1 in 8 maternal deaths occurs during postpartum days 1-6.<sup>1</sup> The United States has the highest maternal mortality rate of any economically developed country in the world, with a rate approximately 10-times higher than the five best-performing countries (see graph below). African American women have an even higher mortality rate- more than double that of other U.S. women.<sup>1</sup> For additional context, Maryland ranked 21<sup>st</sup> in maternal mortality rate compared to other states between 2019-2023.<sup>2</sup>

The 24–48-hour callback window was the result of a consensus opinion of a stakeholder workgroup convened during the 2024 General Assembly session. Workgroup members included the Maryland Hospital Association, the Maryland Department of Health, MACHO, and various public and private agencies vested in maternal healthcare. It was acknowledged by the stakeholders that multiple dangerous postpartum conditions, including opioid overdose risk (the leading cause of maternal mortality in Maryland)<sup>3</sup>, complications of preeclampsia, wound infections, and sequelae of postpartum hemorrhage can worsen during the first 48-hours after hospital discharge.<sup>1,3,4,5</sup>

The United States continues to have the highest maternal death rate, with the rate for Black women by far the highest of any group.

*Maternal deaths per 100,000 live births*



Most women without immediate access to outpatient treatment for opioid use disorder will go into significant withdrawal between 24-48 hours of discharge from the hospital. Without access to care, these patients will very likely resume illicit drug use, along with its associated risks. Overdose remains the leading cause of maternal mortality in Maryland, resulting in 3 times more deaths than the next leading cause (cardiovascular conditions).<sup>3</sup> Timely contact of these patients during the 24–48-hour post-discharge window can identify individuals in need of care and help coordinate bridge therapy until they can link with a full-time outpatient healthcare provider. In addition to concerns about those with substance use disorder, 90% of cases of severe postpartum preeclampsia occur within 1 week of hospital discharge.<sup>4</sup> Delay in contacting these patients by even one additional day can result in missed opportunities to initiate life-saving treatment.

SB 348

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Pg 2

For years, it has been standard of care for hospitals to contact patients undergoing any type of surgery within 24 hours of discharge to assess their well-being. Because of the specific types of health complications that can happen after delivery of a baby, the consensus opinion of the 2024 Legislative Workgroup identified 24-48 hours post-discharge as the ideal time to contact high-risk mothers. MACHO believes it is at least as important for hospitals and birthing centers to devote similar resources to assess the well-being of **high-risk** mothers as is currently done for someone discharged after a minor outpatient surgery.

We believe the burden on hospitals under existing law is minimal. Since the requirement is limited to high-risk women, most rural hospitals will only need to contact 1-3 patients per week. For large hospitals, the requirement will amount to several patients per day, but this is much less than the number of postoperative patients hospitals have been able to successfully contact for many years. Staff capable of fulfilling this duty include labor and delivery nurses, postpartum nurses, nurses working at hospital-associated outpatient obstetric offices, obstetric residents, and obstetric attending physicians. Staff can make these calls from the hospital, office, or their home. Hospital networks sharing electronic health records can consolidate calls across their system to dedicated personnel.

It is particularly important for these calls to continue to take place on weekends. Almost all obstetric offices and prenatal clinics are closed on weekends. Women who begin to display worrisome symptoms on Saturday or Sunday may delay timely, and potentially lifesaving access to care without the hospital-based outreach required under existing statute. Maryland's maternal mortality rate, like that across the U.S., is shockingly high. We can do better. Maryland should not backpedal on a relatively new strategy that has the potential to help save lives.

For these reasons, the Maryland Association of County Health Officers submits written testimony in opposition to SB 348. For more information, please contact Ruth Maiorana, MACHO Executive Director at [rmaiora1@jhu.edu](mailto:rmaiora1@jhu.edu) or 410-937-1433. *This communication reflects the position of MACHO.*

1 <https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison>.

2 <https://www.commonwealthfund.org/publications/issue-briefs/2025/jul/maternal-mortality-united-states-2025>

3 <https://health.maryland.gov/phpa/mch/Documents/MMR/2022%20MMR%20Report.pdf>

4 Al-Safi, Z. E. *Obstet Gynecol.* 2011 Nov;118(5):1102-1107

5 [https://www.ajog.org/article/S0002-9378\(20\)32214-6/fulltext](https://www.ajog.org/article/S0002-9378(20)32214-6/fulltext)