SB348 - SUP - Maternal Health - Collins.pdf
Uploaded by: Quinn Collins
Position: FAV

JOHNS HOPKINS
UNIVERSITY & MEDICINE

TO: The Honorable Pamela Beidle, Chair
Senate Finance Committee

SB348
Favorable

FROM: Quinn Collins
Executive Director, Nursing Strategy & Integration
Johns Hopkins Health System

DATE: February 10, 2026

RE: SB348 Postpartum Communication Requirements: Clinical Evidence, SUD Intent, Operational Impact, and Statutory Authority

Johns Hopkins supports **SB348 Postpartum Communication Requirements: Clinical Evidence, SUD Intent, Operational Impact, and Statutory Authority**. This bill updates the requirements for hospitals to contact birthing parents with high-risk pregnancies from within 48 hours to within 72 hours. This slight but meaningful change will have a huge impact on the hospital workflow and nursing staff, without compromising patient outcomes.

Johns Hopkins fully supports the Maryland Maternal Health Act of 2024 and is proud to be in a state that takes maternal health so seriously. Johns Hopkins Medicine offers comprehensive, family-centered birthing services in Baltimore and Howard County to over 2,4000 babies annually. Our facilities include private labor, delivery, and recovery (LDR) rooms, in-room "rooming in" for newborns, and Level III+ NICU care. We emphasize immediate skin-to-skin bonding, breastfeeding support, and, as a Baby-Friendly designated facility, provide specialized care for both low-risk and high-risk pregnancies.

We have found the calls to the patients to be resource intensive, but valuable. For example, at Johns Hopkins Bayview Medical Center our nurses currently call all postpartum patients because about 2/3 of our moms would be considered “high risk”, so we don’t limit this care to “high risk pregnancy”. As a result, our nurses made 603 calls this academic year. Each call takes about 15 minutes and for the patient population at Bayview, about 50% of the calls require an interpreter due to language barriers.

Extending the time frame for when patients would have to be contacted by this minimum amount would help our staff greatly, by allowing for necessary flexibility (i.e., weekends, holidays) without compromising care. All national clinical guidelines recommend following up with patients within weeks, not days. We are confident extending the outreach to patients just 24 hours, to 72 would still allow for appropriate intervention, should it be necessary.

We are grateful for the Sponsor’s consideration of hospital’s operational concerns, without conceding the original intent of the bill – ensuring women who are post-partum get the highest quality of care. Accordingly, Johns Hopkins respectfully requests a **FAVORABLE** committee report on SB364.

LBH SWA Senate Bill 348 Maternal Health Act Post

Uploaded by: Joy Schucker, MSN, RN

Position: FWA

LIFEBRIDGE HEALTH®

Date: February 10, 2026
To: Chair Beidle and Members of the Senate Finance Committee
Re: Senate Bill 348 – Maternal Health Act – Postpartum Outreach Requirements
Position: Favorable with Amendments

Dear Chair Beidle and Committee Members,

On behalf of Sinai Hospital, thank you for the opportunity to testify in support of Senate Bill 348, which advances a more patient-centered, compassionate, and clinically appropriate approach to postpartum care. Sinai Hospital strongly supports the intent of the Maternal Health Act—to ensure that birthing parents receive timely and meaningful support after discharge, particularly those at highest risk for complications. SB 348 thoughtfully refines the law to better align with patient needs, clinical best practices, and continuity of care.

The postpartum period is not one-size-fits-all. For some patients—particularly those with certain medical complications—post-discharge contact within 24–48 hours is critical. For others, outreach that occurs slightly later but through a trusted and accessible modality is more effective. SB 348 preserves the ability for hospitals to act quickly when clinically necessary, while avoiding rigid requirements that do not improve patient outcomes.

Sinai Hospital recognizes that early post-discharge contact within 24–48 hours can be essential for specific high-risk patients, including those with:

- Severe hypertensive disorders of pregnancy
- Significant postpartum bleeding risks
- Complex medical comorbidities
- Acute behavioral health or safety concerns

In these situations, timely outreach—often coordinated with the patient's OB-GYN or midwife—can be lifesaving. Hospitals already prioritize these patients for rapid follow-up based on clinical judgment, discharge planning, and individualized risk assessment. SB 348 does not diminish this practice; rather, it preserves flexibility so clinicians can respond when urgency is clinically indicated, not simply when required by statute.

For many birthing parents, however, the immediate 24–48 hour window is marked by physical recovery, pain management, sleep deprivation, and newborn care. During this time, patients may miss phone calls or be unable to engage meaningfully, even when outreach occurs. When contact is delayed slightly—or delivered through a preferred modality such as secure text or a patient portal—engagement and trust often improve. *We strive to respect patient choice and coordinate with patients and family the best methods in contacting them based on their preferences.*

Extending the outreach window to 72 hours remains well within accepted definitions of early postpartum care and aligns with clinical pathways for conditions such as hypertensive disorders of pregnancy, which frequently reference provider contact within 48–72 hours after discharge.

For patients with substance use disorders, SAMHSA guidance emphasizes that effective care depends on consistent, trust-based, and individualized engagement over time, rather than rigid timelines. Multiple modalities and sustained connection are central to successful postpartum recovery.

The current statute applies broadly to "high-risk pregnancies," a term that is undefined in law and expansive in practice. As a result, hospitals often over-include—contacting all postpartum patients to avoid missing someone—diluting attention and resources from patients who truly require immediate support.

Finally, *Sinai Hospital emphasizes that the most important relationship for postpartum recovery is the ongoing connection between the birthing parent and their OB-GYN or midwife*. These providers are best positioned to monitor recovery, manage complications, and support long-term maternal health. Hospital outreach should reinforce—not disrupt—this trusted relationship.

SB 348 supports a coordinated, patient-centered model that prioritizes continuity, respects patient preferences, and improves maternal outcomes. SB 348 strikes the right balance between urgency and flexibility, ensuring that patients who need immediate post-discharge contact receive it, while allowing care teams to engage others in ways that are realistic, respectful, and effective. By aligning statutory requirements with clinical judgment and patient experience, this bill strengthens postpartum care across Maryland.

For these reasons, Sinai Hospital respectfully urges adoption of proposed amendments by MHA with a favorable report on SB 348.

Thank you for your consideration.

Joy Schucker, MSN, RN
Sinai Hospital-Women's Clinical Outcomes Specialist
410-601-0976 jschucker@lifebridgehealth.org

Jennifer Witten, MBA
Vice President Government Relations & Community Development
LifeBridge Health | 10090 Red Run Blvd. Owings Mills, MD 21117 | 505.688.3495
jwitten2@lifebridgehealth.org

Amendment:
Pg 2. Line 20 (3) Contact ~~Call~~ the birthing parent at least 24, but not later than [48] 72, hours 21 after discharging the parent to evaluate the parent's status and, as necessary, provide 22 information about postpartum complications.

SB 348 - Hospitals and Freestanding Birthing Cente

Uploaded by: Kimberly Routson

Position: FWA

MedStar Health

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Kimberly S. Routson
Assistant Vice President
Government Affairs - Maryland

SB 348 - Hospitals and Freestanding Birthing Centers – High–Risk Pregnancies – Communication After Discharge
Position: ***Support with Amendments***
Senate Finance Committee
February 10, 2026

MedStar Health is the largest healthcare provider in the Maryland and Washington, D.C. region. MedStar Health offers a comprehensive spectrum of clinical services through over 500 care locations, including 10 hospitals, 33 urgent care clinics, ambulatory care centers and an extensive array of primary and specialty care providers. As a not-for-profit healthcare system, MedStar Health is committed to its patient-first philosophy, emphasizing care, compassion, and clinical excellence, supported by a dedicated team of more than 35,000 physicians, nurses, and many other clinical and non-clinical associates.

The Maryland Maternal Health Act requires hospitals to call the birthing parent at least 24 hours, but not later than 48 hours, after discharging the parent to evaluate the parent's status and, as necessary, provide information about postpartum complications following a high-risk pregnancy. Senate Bill 348 would shift the contact window to 24 hours to 72 hours. MedStar Health is also advocating for an amendment that would change the word "call" to "contact" in the legislation to allow for additional outreach modalities, including text, to reach patients.

MedStar Health practitioners have struggled to connect by phone in the 24-48 hour timeframe required by law. The majority of patients are "unable to reach" or "decline" in our call data. Since the implementation of the calls on July 1, 2025, the rate of call engagement is only 34% for all postpartum patients of MedStar birthing hospitals across the state.

The Safe Babies Safe Moms (SBSM) program at MedStar Washington Hospital Center has tested innovative approaches to improve maternal and infant health outcomes and promote health equity and shown that it is possible to reduce disparities in birth outcomes using targeted, evidence-based strategies[1]. SBSM uses texting to connect with postpartum mothers and has demonstrated a 67% engagement rate. In addition to higher initial engagement, the text system ensures that questions and issues are routed to the right clinicians and individuals can receive the resources they require for both them and the baby. Our operational experience convinces us that in this cohort of young people, we will achieve a higher engagement rate incorporating SMS messaging with calls, and a growing body of research supports this conclusion.

Expanding the timeline and modality will give our team the best chance to connect with patients to answer questions about themselves and their newborns, share postpartum warning signs, and discuss when to call their doctor or seek emergent care. Adding additional flexibility into the statute ensures that Maryland continues to drive down health disparities while respecting patient choice and communication preferences. For the reasons above, MedStar Health urges a ***favorable with amendments*** report on **SB 348**.

[1] ***D.C. Safe Babies Safe Moms: A Novel, Multigenerational Model to Reduce Maternal and Infant Health Disparities,*** *NEJM Catalyst Innovations in Care Delivery*, DOI: 10.1056/CAT.24.0161, https://catalyst.nejm.org/doi/10.1056/CAT.24.0161

SB 348 – High-Risk Pregnancies – Post-Discharge Co

Uploaded by: Natasha Mehu

Position: FWA

Maryland
Hospital Association

Senate Bill 348- Hospitals and Freestanding Birthing Centers - High-Risk Pregnancies - Communication After Discharge

Position: ***Support with Amendments***
February 10, 2026
Senate Finance Committee

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in support with amendments on Senate Bill 384 to ensure the statute aligns with clinical best practices and can be implemented effectively in hospital settings.

Hospitals strongly support the intent to promote early postpartum engagement and education for birthing parents with high-risk pregnancies. However, the current statute requires hospitals to meet highly specific timing and modality requirements for contacting high-risk birthing parents post-discharge. Since this statute went into effect, frontline hospital staff, including nurses and care coordinators, say it has been challenging to meet these prescriptive requirements.

SB 348 would change the time period for post-discharge calls from 24 to 48 hours to 24 to 72 hours. MHA proposes an amendment that would allow for additional contact methods, such as text message or email. These targeted statutory changes align with clinical guidelines and are necessary to improve patient engagement and hospital outreach while ensuring the law continues to function as intended.

Clinical Considerations
There is no national clinical guideline requiring postpartum outreach to occur specifically within 24 to 48 hours following discharge. Leading professional organizations, such as the American College of Obstetrics and Gynecology, describe postpartum care as an ongoing process that emphasizes early engagement combined with continuity of care, rather than a rigid, single-touchpoint timeframe. A 72-hour outreach window remains clinically appropriate, including for high-risk patients. [1,2,3]

For example, accepted care pathways for serious postpartum complications, particularly hypertensive disorders of pregnancy, frequently reference provider follow-up within 48 to 72 hours after discharge.[1,3] Extending the allowable outreach window to 72 hours thus, preserves early postpartum contact while better reflecting clinical practice and patient recovery patterns.

Patient Engagement and Effectiveness
Hospitals report consistent difficulty reaching patients by phone within the current 24 to 48 hour requirement. During this period, patients are often recovering from childbirth, caring for

[1] ACOG Committee Opinion No. 736: Optimizing Postpartum Care. Obstetrics & Gynecology 131(5):p e140-e150, May 2018
[2] https://www.cmqcc.org/postpartum-discharge-resource/hypertension-pregnancy-follow
[3] https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs//141-004-PostpartumFollowupCareSchedule.pdf

newborns, or navigating work, childcare, and housing challenges. These barriers disproportionately affect high-risk populations. The odds of receiving a response from patients can be especially lower when this 48-hour window coincides with weekends or holidays. A modest 24-hour extension can help ensure providers have sufficient time to make effective contact with all high-risk patients.

For many high-risk postpartum patients, phone calls are also not always the most reliable way to make contact. Allowing hospitals to contact patients through multiple modalities, rather than exclusively via phone calls, improves the likelihood of successful engagement and ensures that patients have the flexibility to respond when they are able, while simultaneously navigating multiple post-partum responsibilities and challenges.[4] Many hospitals have demonstrated greater success in contacting patients by text message, email, or their preferred method of communication.

Substance Use Disorder and High-Risk Care
Some stakeholders have indicated that the underlying requirement was intended, in part, to support postpartum patients with substance use disorders. Hospitals share this goal. However, best practices for postpartum substance use disorder care emphasize continuity, trust-based engagement, and multiple touchpoints over time rather than a single, narrowly timed phone call within a specified window of time.[5,6]

Flexibility in timing and method of contact better supports individualized engagement strategies for patients with complex needs while avoiding stigma and improving the likelihood of meaningful connection. As such, SB 348 does not undermine the original bill's intent, but seeks to strengthen implementation based on what hospitals and providers are observing in practice.

Amendment

MHA supports the goals of SB 348 and respectfully urges the Committee to adopt an amendment that replaces the requirement to "call" a patient with the requirement to "contact" a patient.

Amendment No.1

On page 2, in line 20, strike "Call" and insert "Contact."

For these reasons, MHA requests a favorable report with amendments on Senate Bill 348.

For more information, please contact:
Natasha Mehu, Vice President, Government Affairs & Policy
Nmehu@mhaonline.org

[4] Hirshberg A, Downes K, Srinivas S. Comparing standard office-based follow-up with text-based remote monitoring in the management of postpartum hypertension: a randomized clinical trial. *BMJ Quality & Safety* 2018;**27:**871-877.
[5] https://www.ajog.org/article/S0002-9378(13)01058-2/fulltext
[6] https://library.samhsa.gov/sites/default/files/sma18-5054.pdf

SB348_FinalReprint
Uploaded by: Senator Jackson
Position: FWA

SENATE BILL 348

J1, J3 6lr2497

By: **Senator Jackson**
Introduced and read first time: January 23, 2026
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Hospitals and Freestanding Birthing Centers – High–Risk Pregnancies – Communication After Discharge

FOR the purpose of altering the ~~time period~~ requirement that a hospital or freestanding birthing center contact the birth parent after the delivery of a newborn following a high–risk pregnancy ~~in which a hospital or freestanding birthing center must call the birthing parent to evaluate the birthing parent's status and, as necessary, provide certain information~~ for a certain purpose to remove the requirement that the contact be made through a call and to lengthen the time period within which the contact must be made; and generally relating to hospitals and freestanding birthing centers and high–risk pregnancies.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–310.5 and 19–3B–03.1
Annotated Code of Maryland
(2023 Replacement Volume and 2025 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–310.5.

(a) If a newborn is delivered in a hospital following a high–risk pregnancy, the hospital shall:

(1) Complete a postpartum infant and maternal referral form and submit the form to the local health department for the county in which the birthing parent resides;

(2) Provide to the birthing parent resources and information specific to the circumstances of the birthing parent, including information regarding the risks, signs, preventive measures, and treatment needs for postpartum complications, including

REPRINT OF SENATE BILL 348 as amended by SB0348/483421/1 02/09/26 at 10:16 AM

cardiovascular conditions, chronic disease, substance misuse, and mental health conditions; and

(3) ~~Call~~ **CONTACT** the birthing parent at least 24, but not later than **[**48**]** **72**, hours after discharging the parent to evaluate the parent's status and, as necessary, provide information about postpartum complications.

(b) On or before October 1 each year, each local health department shall submit to the Department a report that includes the number and type of referrals made based on the referral forms submitted to the local health department in accordance with subsection (a)(1) of this section.

19–3B–03.1.

(a) If a newborn is delivered in a freestanding birthing center following a high–risk pregnancy, the freestanding birthing center shall:

(1) Complete a postpartum infant and maternal referral form and submit the form to the local health department for the county in which the birthing parent resides;

(2) Provide to the birthing parent resources and information specific to the circumstances of the birthing parent, including information regarding the risks, signs, preventive measures, and treatment needs for postpartum complications, including cardiovascular conditions, chronic disease, substance misuse, and mental health conditions; and

(3) ~~Call~~ **CONTACT** the birthing parent at least 24, but not later than **[**48**]** **72**, hours after discharging the parent to evaluate the parent's status and, as necessary, provide information about postpartum complications.

(b) On or before October 1 each year, each local health department shall submit to the Department a report that includes the number and type of referrals made based on the referral forms submitted to the local health department in accordance with subsection (a)(1) of this section.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2026.

SB348_SponsorAmendent
Uploaded by: Senator Jackson
Position: FWA

SB0348/483421/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

09 FEB 26
10:17:17

BY: Senator Jackson
(To be offered in the Finance Committee)

AMENDMENTS TO SENATE BILL 348
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 4, strike "time period" and substitute "requirement that a hospital or freestanding birthing center contact the birth parent"; and strike beginning with "in" in line 5 down through "information" in line 7 and substitute "for a certain purpose to remove the requirement that the contact be made through a call and to lengthen the time period within which the contact must be made".

AMENDMENT NO. 2

On page 2, in lines 3 and 20, in each instance, strike "Call" and substitute "**CONTACT**".

SB0348_UNF_MDACOG_Hospitals & Freestanding Birthin
Uploaded by: Christine Krone
Position: UNF

ACOG
The American College of Obstetricians and Gynecologists

Maryland Section

Senate Finance Committee
February 10, 2026
Senate Bill 348 – *Hospitals and Freestanding Birthing Centers – High-Risk Pregnancies – Communication After Discharge*
POSITION: OPPOSE

The American College of Obstetricians and Gynecologists, Maryland Section (MD ACOG), which represents the Maryland physicians who serve the obstetrical and gynecological needs of Maryland women and their families, **opposes** Senate Bill 348.

Senate Bill 348 proposes two amendments to a provision of the Maryland Maternal Health Act of 2024. First, it would replace the word "call" with "contact," allowing hospitals to use alternative methods—such as text messaging or other modalities—to reach patients following discharge. Second, it would extend the required follow-up period for hospital staff from 24–48 hours to 24–72 hours after discharge.

The Maryland Maternal Health Act of 2024, including this follow-up requirement, was the product of an extensive, collaborative, and highly intentional process. OB/GYNs, midwives, doulas, nurses, hospitals, insurers, local health departments, the Maryland Department of Health, patients, advocates, and professional membership organizations participated in workgroup meetings both during the interim and throughout the legislative session. Every provision of the Act, including the 24–48-hour follow-up window, was carefully considered and deliberately drafted. Nothing in the statute was arbitrary or subjective.

The 24–48-hour follow-up period is a safeguard that should be maintained. Early post-discharge contact is particularly important for identifying complications, addressing urgent clinical concerns, and connecting patients with needed support during a highly vulnerable period. Extending this window risks delaying identification of serious issues and undermines the intent of the original legislation.

For these reasons, MD ACOG strongly urges the Committee to reject the proposed extension of the follow-up timeframe and to preserve the 24–48-hour window as enacted in the Maryland Maternal Health Act of 2024. If the Committee determines that a statutory change is necessary, MD ACOG would not oppose replacing the word "call" with "contact" to allow flexibility in how hospitals successfully reach patients using appropriate and patient-centered communication methods.

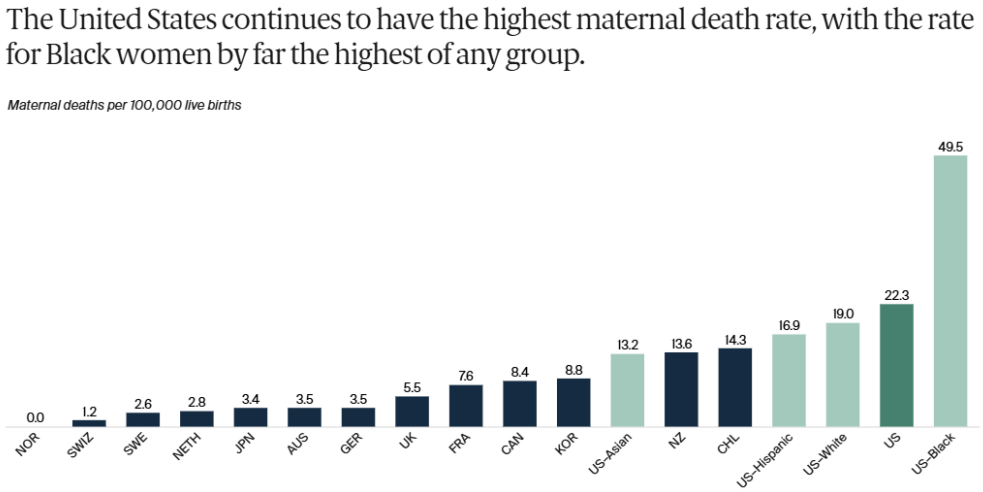
For more information call:
Christine K. Krone
J. Steven Wise
Danna L. Kauffman
410-244-7000

SB 348 - Hosp and Freestanding Birth Ctrs – High–R
Uploaded by: Larry Polsky
Position: UNF

SB 348
Hospitals and Freestanding Birthing Centers – High–Risk Pregnancies - Communication After Discharge
WRITTEN TESTIMONY BEFORE THE SENATE FINANCE COMMITTEE
Laurence Polsky, MD, MPH, FACOG, Medical Director, Calvert County Health Department
For the Maryland Association of County Health Officers (MACHO)
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.[1] 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.[1] For additional context, Maryland ranked 21st in maternal mortality rate compared to other states between 2019-2023.[2]

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)[3], complications of preeclampsia, wound infections, and sequalae of postpartum hemorrhage can worsen during the first 48-hours after hospital discharge.[1,3,4,5]



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).[3] 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.[4] Delay in contacting these patients by even one additional day can result in missed opportunities to initiate life-saving treatment.

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 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

2026 ACNM SB 348 Senate.pdf
Uploaded by: Robyn Elliott
Position: UNF

AFFILIATE OF
AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

Committee:	**Senate Finance Committee**
Bill:	**Senate Bill 348 - Hospitals and Freestanding Birthing Centers – High–Risk Pregnancies –Communication After Discharge**
Hearing Date:	**February 10, 2026**
Position:	**Oppose**

The Maryland Affiliate of the American College of Nurse Midwives (ACNM) opposes *Senate Bill 348 - Hospitals and Freestanding Birthing Centers – High–Risk Pregnancies Communication After Discharge.* The bill proposes changing the timeframe from when hospitals call the birthing parent from 48 to 72 hours in high-risk cases. This proposal would alter the implementation of the *Maryland Maternal Health Act of 2024 (HB 1051/SB 1059).*

ACNM appreciates the intent of the bill to address an implementation question experienced by some hospitals. However, we are deeply concerned that the bill will unravel the system of care built by the *Maryland Maternal Health Act of 2024*. According to the Commonwealth Fund:

> "While efforts are underway to improve clinical care at the time of birth, comprehensive solutions to prevent maternal deaths must ultimately involve health care systems, community-based birth and maternity care systems, policymaking, and clinical and social interventions before, during, ***and after*** pregnancy."[i]

There are many risks faced by new birthing parents, including postpartum preeclampsia which can develop within a few days after birth even when blood pressure had been normal during pregnancy.[ii] Birthing parents who are impacted by a substance use disorder are also at high risk in experiencing severe symptoms of withdrawal which means contact with the healthcare system immediately after discharge is important.[iii]

ACNM is committed to developing the infrastructure system to support effective and efficient postpartum care. We ask that the Committee not move forward on Senate Bill 348. Maryland is ranked 21st in our maternal mortality rate.[iv] The healthcare community need more

time to work on implementation. We would be eager to work with other providers, hospitals, and local health departments to support implementation of the *Maternal Mental Health Act of 2024*.

If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

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[i] https://www.commonwealthfund.org/publications/issue-briefs/2025/jul/maternal-mortality-united-states-2025

[ii] https://www.acog.org/womens-health/experts-and-stories/the-latest/3-conditions-to-watch-for-after-childbirth

[iii] https://pmc.ncbi.nlm.nih.gov/articles/PMC8490333/

[iv] https://www.commonwealthfund.org/publications/issue-briefs/2025/jul/maternal-mortality-united-states-2025

SB 348 - FIN - MACHO - LOO.pdf
Uploaded by: State of Maryland (MD)
Position: UNF

SB 348

Hospitals and Freestanding Birthing Centers – High–Risk Pregnancies - Communication After Discharge

WRITTEN TESTIMONY BEFORE THE SENATE FINANCE COMMITTEE

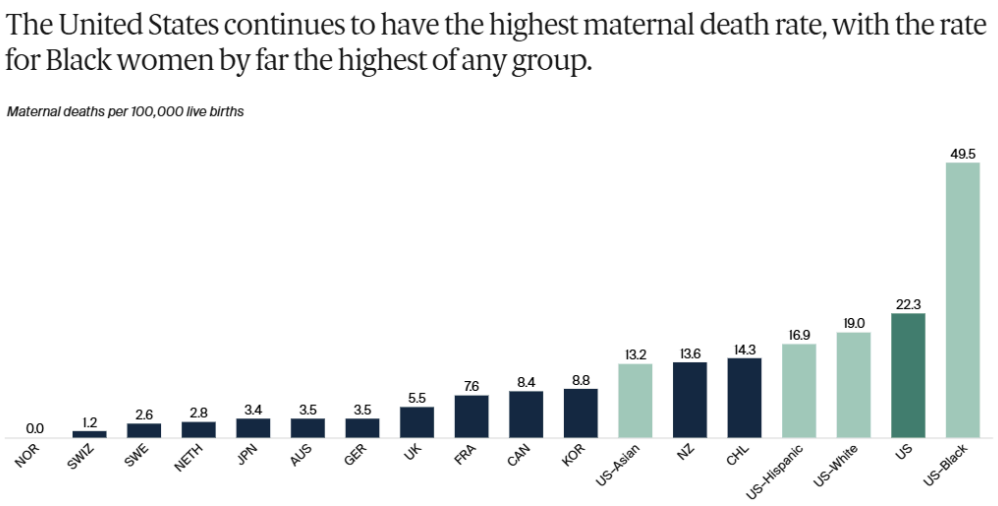
Laurence Polsky, MD, MPH, FACOG, Medical Director, Calvert County Health Department

For the Maryland Association of County Health Officers (MACHO)

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.[1] 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.[1] For additional context, Maryland ranked 21st in maternal mortality rate compared to other states between 2019-2023.[2]

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)[3], complications of preeclampsia, wound infections, and sequalae of postpartum hemorrhage can worsen during the first 48-hours after hospital discharge.[1,3,4,5]



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).[3] 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.[4] Delay in contacting these patients by even one additional day can result in missed opportunities to initiate life-saving treatment.

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 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

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Position: UNF

MARYLAND BLACK PERINATAL HEALTH & REPRODUCTIVE JUSTICE POLICY COLLECTIVE

Committee: Senate Finance Committee

Bill: Senate Bill 348 – Hospitals and Freestanding Birthing Centers – High Risk Pregnancies – Communication After Discharge

Hearing Date: February 10, 2026

Position: Oppose

On behalf of the Maryland Black Perinatal Health and Reproductive Justice Policy Collective, we submit this testimony in opposition to Senate Bill 348.

Maryland is facing an ongoing maternal health crisis. With our state being ranked 21st in maternal mortality, Black mothers and birthing people continue to experience the highest rates of preventable maternal death and severe maternal morbidity. These outcomes are not accidental – they are the result of systemic failures across the healthcare delivery, policy implementation, and postpartum support. At a time when Maryland has taken meaningful steps forward through the Maryland the Maryland Maternal Health Act of 2024 (HB 1051/SB 1059), it is critical that we do not weaken the intentional systems designed to save lives.

While we acknowledge the intent of Senate Bill 348 to address implementation challenges experienced by some hospitals, we also understand that this should be a priority for all hospitals and not be seen as a burden. In addition, changing the required postpartum communication timeframe to 48 to 72 hours for high-risk pregnancies risks unraveling a system of care that is still in its earliest and most fragile stages. For Black birthing people, who are more likely to experience delayed diagnoses, dismissal of systems, and barriers to follow-up care, timely postpartum contact is not simply a procedural requirement—it's a life saving intervention.

As the Black Mamas Matter Alliance (BMMA) affirms, improving Black maternal health outcomes requires a reproductive justice and human rights-based approach that prioritizes continuity of care, accountability within health systems, and robust postpartum support. BMMA's policy framework[1] emphasizes that the postpartum period is one of the most critical- and dangerous-times for birthing people, and that early engagement with healthcare systems is essential to preventing maternal health death and long-term harm.

The Commonwealth Fund[2] similarly underscores that preventing maternal deaths requires comprehensive solutions across healthcare systems, community based perinatal care, policy and social interventions before, during and after pregnancy. The 24 to 48 hour postpartum communication requirement is one such intervention, recognizing that the immediate days following discharge are often when complications emerge and when timely response can make the difference between recovery and crisis.

Postpartum preeclampsia can develop within days after birth, even among individuals who had normal blood pressure during pregnancy. Delays in postpartum follow-up can result in missed warning signs, escalation of symptoms, and preventable maternal deaths. Birthing people impacted by substance use disorder are also at heightened risk in the immediate postpartum period, including experiencing severe withdrawal symptoms or overdose, making early and consistent contact with the healthcare system essential.

For Black mothers and birthing people, these risks are compounded by structural racism, fragmented systems of care, and a long history of being unheard or undertreated within medical settings. Any policy change that delays postpartum engagement—particularly for those already deemed high-risk, deepens inequity and undermines Maryland's commitment to advancing Black maternal health and reproductive justice.

The Maryland Black Perinatal Health and Reproductive Justice Policy Collective believes that now is not the time to scale back postpartum protections. Instead, the healthcare community needs more time, resources and collaboration to fully and effectively implement the Maryland Maternal Health Act of 2024 as intended. This aligns with our collective call to strengthen postpartum care systems and to invest in policies that prioritizes safety, dignity, and quality of life for all Marylanders, especially Black birthing people.

We stand ready to work collectively with hospitals, providers, local health departments, community organizations and practitioners, and policymakers to support thoughtful implementation that centers equity and accountability. Maintaining timely postpartum communication is a critical part of ensuring not only survival, but a better quality of life for families across Maryland.

For these reasons, we respectfully ask the Committee not to move forward with Senate Bill 348.

Thank you for your time, consideration, and commitment to protecting the lives of Maryland's birthing people.

If we can provide any additional information, please do not hesitate to reach out to Tanay Lynn Harris at Tanay@BloominBaltimore.com or 202.394.0694

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[1] Black Mamas Matter Alliance: In Policy and Practice, 2023

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

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Maryland
DEPARTMENT OF HEALTH
Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

February 10, 2026

The Honorable Pamela Beidle
Chair, Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: Senate Bill 348 – Hospitals and Freestanding Birthing Centers - High-Risk Pregnancies - Communication After Discharge – Letter of Information

Dear Chair Beidle and Committee members:

The Maryland Department of Health (the Department) respectfully submits this letter of information for Senate Bill (SB) 348 – Hospitals and Freestanding Birthing Centers - High-Risk Pregnancies - Communication After Discharge. This bill modifies a portion of the 2024 Maternal Health Act related to post-discharge follow-up requirements for high-risk pregnancies by extending the timeframe in which a hospital or freestanding birth center must call the birthing parent from 24–48 hours to 24–72 hours after discharge to assess status and provide information as needed.[1]

High-risk patients are those with risk factors or complications during delivery that make them more vulnerable for severe morbidity and mortality in the postpartum period. The purpose of the post-discharge phone call is to connect with patients who may need assistance but have not sought it, to identify concerning symptoms that may be going unrecognized, and to ensure that birthing people in Maryland feel supported by their clinical providers during this critical period. It aligns with the Alliance for Innovation on Maternal Health (AIM) Postpartum Discharge Transition Bundle, which requires hospitals to "facilitate *and assure* linkage to relevant services in outpatient settings for care identified for postpartum risk factors".[2]

The high-risk groups most likely to benefit from post-discharge follow up include: those with a history of preeclampsia, hypertension, substance use disorder, or who underwent cesarean delivery; those with prior hemorrhage; and individuals with limited home support or facing language barriers or low health literacy. These risk factors contribute to racial and ethnic disparities in maternal health outcomes in the state because they are not distributed or experienced equally. The Department is not aware of specific research comparing the efficacy of post-discharge phone calls at 48 hours to 72 hours. However, from a clinical perspective, a phone

[1] Maryland General Assembly. (2024). House Bill 1051/Senate Bill 1059.
[2] Available at: https://saferbirth.org/psbs/postpartum-discharge-transition/

call within 48 hours may present a stronger and more timely opportunity to address issues like hypertension and preeclampsia that are at high risk of worsening in the first 48 hours after discharge while also helping to prevent other complications, like hemorrhage, which could occur at a later date. Extending the follow-up time period to 72 hours could also create a gap in support for some patients. If this gap occurs over a weekend and no call is made, it misses a critical point when birthing people have the fewest resources at their disposal and feel the most isolated. Access to care is often restricted over weekends: prenatal and primary care offices typically close, while lactation support services and pharmacies operate on reduced schedules.

The Department acknowledges that hospitals may require additional staffing to make these calls on the weekend. We also understand that patient communication preferences may vary, and we encourage hospitals to use text, email, or other communications in addition to an initial call as needed. The most important part of the outreach to patients is that it allows for two-way communication to support them with their individual needs.

This type of patient follow up is a valuable, and time-sensitive, resource for birthing people; an opportunity to bridge the divide between inpatient care and outpatient wellbeing for birthing people in the United States, and it should be directed toward the timeframe with the greatest chance for impact and prevention.

If you would like to discuss this further, please do not hesitate to contact Meghan Lynch, Director of Governmental Affairs at meghan.lynch@maryland.gov.

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary