Assessing Maryland's Approach to Maternal and Newborn Health: Legislative Barriers and Policy Alternatives

Trevor Guesno, Dylan Harvey, and Kristen McCurdy
PLCY688U/PLCY400 – Final Report
Instructor: Patrina Clark
December 19, 2025

Table of Contents

Abstract

Maryland continues to experience persistent disparities in maternal and newborn health outcomes, particularly among Black mothers and families in rural jurisdictions. Although evidence-based home visiting programs are proven to support healthier births, improve child development, and strengthen family stability, Maryland's fragmented infrastructure and limited capacity restrict program reach across the state. This report evaluates Maryland's current maternal and newborn health landscape and analyzes policy alternatives that could expand access to postpartum supports while strengthening system coordination. Through a review of statewide needs assessments, national research on home visiting models, and emerging implementation evidence, we assess the feasibility, scalability, and equity impacts of multiple strategies, including enhanced support for existing programs, community health worker pilots, Social Impact Bond financing, and expanded postpartum access through PATTY Centers. Our recommendations outline a phased approach that stabilizes Maryland's current system while advancing toward a long-term vision of universal, equitable support for all new families. Together, these strategies offer a pathway for Maryland to reduce racial and geographic disparities and improve maternal and infant outcomes through more coordinated, sustainable, and cost-effective care.

Introduction

Maryland has made notable progress in improving overall maternal and infant health, yet stark racial and geographic disparities persist. Black mothers in Maryland remain far more likely to experience pregnancy-related complications, preterm birth, low-birthweight infants, and maternal or infant mortality than white mothers. These inequities are further intensified in rural

jurisdictions, where gaps in access to quality care and workforce shortages continue to undermine health outcomes. Such disparities reflect structural inequities in economic stability, health care access, and social supports. These factors shape family wellbeing long before childbirth and continue throughout the postpartum period.

Evidence-based home visiting programs provide a proven strategy for strengthening maternal and newborn health by connecting families with clinical support, behavioral health services, and community resources during a critical period of development. However, Maryland's current system reaches only a fraction of families who could benefit. Fragmented coordination, workforce instability, uneven data systems, and short-term funding all limit consistency and scope statewide.

In response to these challenges and recent legislative movement at the state level, the Maryland Commission for Women (MCW) requested this report to assess the current landscape, analyze barriers to equitable access, and identify feasible policy options that can improve postpartum support for Maryland families. This work aligns with growing legislative interest, including the establishment of a Workgroup on Universal Newborn Nurse Home Visiting Services, and reflects a broader commitment to strengthening maternal health equity across the state.

To support informed decision-making, this report examines four categories of policy alternatives: (1) stabilizing and enhancing Maryland's existing home visiting infrastructure; (2) expanding postpartum access through Maternal Support (PATTY) Centers; (3) piloting a Community Health Worker–led home visiting model; and (4) exploring Social Impact Bond financing to support targeted implementation. While these near-term strategies address Maryland's immediate fiscal and operational constraints, they also build toward a long-term goal of universal nurse home

visiting; an approach with strong evidence for reducing disparities, improving outcomes, and ensuring every family receives support during the earliest and most consequential weeks of life.

Literature Review

Racial and Geographic Disparities in Maternal and Infant Outcomes

Racial and geographic inequities continue to drive poor maternal and infant health outcomes in Maryland. The 2025 *Maternal, Infant, and Early Childhood Home Visiting Needs Assessment* reports that Black mothers experience higher rates of preterm birth, low birth weight, and infant mortality than white mothers, with the widest gaps in Baltimore City and rural counties (Maryland Department of Health). The Baltimore City *Fetal and Infant Mortality Review* attributes these differences to chronic stress, hypertension, racial residential segregation, and provider bias, noting that many mothers received inadequate prenatal care or lacked postnatal follow-up (Baltimore City Health Department). These disparities persist despite statewide improvement in overall infant health indicators. Scholars emphasize that the causes are structural rather than behavioral, rooted in unequal access to healthcare, economic instability, and social determinants such as housing and transportation (Condon et al.). New mothers who are between the ages of 18 and 24 face a wave of problems during and after pregnancy. In Maryland, 43 programs support education and employment for new mothers. However, according to the Report on the Implementation and Outcomes of State-Funded Home Visiting Programs in Maryland, 63% of these new mothers left the program (Maryland Children's Cabinet, p. 69). Without proper education or employment, there is a higher risk of adverse effects on children with physical health and cognitive development disabilities, which is then further compounded,

as lower education is associated with lower birth weights and increased maternal mortality. Together, these findings illustrate that families of color and those in underserved regions bear a disproportionate burden of health, developmental, and socioeconomic risk, underscoring the need for coordinated, equity-focused policy interventions.

Fragmented and Uneven Program Infrastructure

Maryland's current arrangement of maternal and child health programs operates through disconnected systems, limiting consistency and reach. The *Maryland Maternal, Infant, and Early Childhood Home Visiting Needs Assessment* reports variation in data collection, eligibility criteria, and referral practices across local agencies (Maryland Department of Health) with the Casey Family Programs supporting this claim, noting a similar trend throughout the nation. They continue to identify how the existing child welfare environment nationally, is a "patchwork" of models funded by separate streams that lack coordination and standardization, and when analyzed through the lens of the state, the *Baltimore City Fetal and Infant Mortality Review* equate this fragmentation to gaps in postpartum follow-up and communication among hospitals, home visitors, and community providers (Baltimore City Health Department; Casey Family Programs). In contrast, Frederick Health's *Community Impact Report* highlights the effectiveness of coordinated systems: by linking emergency, behavioral, and home-visiting services, through its Comprehensive Care Center, cut readmissions from 13 percent to 1 percent (Frederick Health).

According to the *Report on the Implementation and Outcomes of State-Funded Home Visiting Programs in Maryland,* the at-home programs Maryland currently supports are under threat of being underserved and understaffed. In 2021, 22% of staff left their home visiting programs, with 54% citing better pay and benefits as the reason for leaving the program (Maryland Children's

Cabinet, pp. 69-70). These problems then multiply as remaining staff are overburdened with more work, which leads to more worker burnout. High turnover and burnout directly constrain the number of families programs can enroll and serve consistently, especially in jurisdictions that already face provider shortages.

Collectively, the literature suggests that better coordination – not just program availability – is essential to achieving equitable statewide outcomes.

Funding and Reach

Maryland's home visiting programs remain limited in scope due to inconsistent and short-term funding. The *Maryland Maternal, Infant, and Early Childhood Home Visiting Needs Assessment* reports that only a small proportion of eligible families receive services, with local programs constrained by workforce shortages and reliance on competitive federal grants (Maryland Department of Health). Casey Family Programs similarly finds that many states depend on fragmented or categorical funding streams that inhibit long-term sustainability and equitable access (Casey Family Programs). Condon et al. argue that this reliance on limited federal allocations forces states to fund only a few evidence-based models rather than developing diverse, needs-based approaches (2019). Recognizing these challenges, the Maryland General Assembly passed *SB156/ HB334* in 2025, not to implement universal home visiting but to establish a workgroup to study feasibility, cost, and insurance coverage options (Maryland General Assembly). The bill's modification underscores the fiscal and political barriers to large-scale implementation. Collectively, the literature suggests that without stable, coordinated funding and bipartisan support, Maryland will continue to struggle to expand equitable home visiting access statewide. While funding instability limits program reach, the literature shows that evidence-based models yield significant health and economic returns when implemented

effectively. In combination, these funding and workforce dynamics reinforce the same inequities identified earlier in the literature: jurisdictions with the greatest maternal and infant needs often have the least stable resources to support home visiting. For Maryland, this means that fiscal and political constraints are not separate from the equity problem, but rather they actively shape which families receive services and which do not.

Effectiveness and Emerging Universal Models

Our research demonstrates that evidence-based home visiting programs improve maternal and infant outcomes across health, social, and economic measures. Casey Family Programs reports that participation in nurse home visiting can reduce substantiated cases of child maltreatment by nearly half and produce returns of $1.80 to $5.70 for every dollar invested, primarily through avoided costs in child protection, health care, special education, and criminal justice systems. These savings refer to public and societal expenditures that are prevented because fewer children require services, hospital care, or legal intervention. (Casey Family Programs). Condon et al. call for a "paradigm shift" in state funding and program design, advocating for a menu of home visiting models that combine universal access with targeted supports to address families' varying needs (Condon et al.). Maryland's *Family Connects Frederick County* program illustrates this approach, achieving 88 percent participation among new parents and reducing hospital readmissions through coordinated community partnerships (Frederick Health). When assessing the Nurse-Family Partnership program, an evidence-based home visiting program implemented in 40 states and currently Maryland's only statewide home nurse visiting program, for cost-effectiveness, it was found that universal implementation would result in an average gain of 0.11 quality-adjusted life years (QALYs) per child and 0.19 QALYs per child for high-risk mothers (Wu, Dean, Rosen, and Muennig). A QALY, or quality-adjusted life year, measures both

the quantity and quality of life by representing one year lived in perfect health, allowing researchers to compare the overall health impact of different interventions. The Maryland General Assembly's creation of a Workgroup on Universal Newborn Nurse Home Visiting Services through *Senate Bill 156* signals growing legislative recognition of these benefits, even as the state evaluates feasibility and funding mechanisms (Maryland General Assembly). According to a randomized trial of nurse specialist home care for women with high-risk pregnancies, outcomes and costs showed that intervention in the case of mothers with low birth weight (LBW) babies supports intervention as it saves both money and lives. Intervention is defined by prenatal care at home, teaching, telephone outreach, and postpartum home visiting (Brooten D, 2001). These factors led the intervention group to have a lower infant mortality rate and fewer hospital days, resulting in an estimated savings of $ 2.8 million. Intervention in the case of LBWs resulted in fewer hospitalizations after birth and fewer hospitalizations for women during pregnancy. Fewer hospitalizations resulted in 39% in-charge savings for hospital stays and savings in rehospitalizations (Brooden, 2001). However, when standardizing care through a universal model, nurse home visiting programs were, on average, the most expensive type of home visiting program due to high personnel costs (Corso et al. 39) and faced significant reductions in cost-benefit in comparison to those that were only focused on high-risk populations (Donelan-McCall, Knudtson, and Olds; Wu et al.). Collectively, the literature positions universal home visiting as both an effective and equitable strategy for improving maternal and infant health statewide.

The literature makes it clear that Maryland continues to face unacceptable maternal and infant mortality rates, particularly among Black mothers and rural communities, due to structural inequities and fragmented systems. Disparities are driven by systemic inequities in access, care

quality, and socioeconomic conditions. Program infrastructure is fragmented, leading to inconsistent outcomes and workforce burnout. A coordinated and equity-focused approach is consistently identified as key to achieving more consistent and sustainable results statewide. These findings underscore the importance of the Maryland Family Network and the Maryland Department of Health in leading a coordinated, sustainable system that ensures equitable home visiting access for all new families.

Data Collection & Analysis

This section synthesizes Maryland-specific data and national evidence to assess the scale of maternal and newborn health needs, identify barriers to equitable program access, and evaluate the potential impact of differing expanded services. We focused our analysis on three main domains: risk factors identifying where disparities are greatest, statewide performance trends demonstrating program outcomes and gaps, and the strength of evidence supporting the proposed policy alternatives. These insights inform the recommendations that follow and help prioritize approaches that can yield the greatest benefit for Maryland families.

Data is collected from primary and secondary sources. These sources range from government reports to private research from independent sources. These sources are up to date with the most current information on the subject. Our analysis is designed to support policy decision-making rather than rank alternatives on a single outcome. The team synthesized Maryland-specific data, national research, and implementation evidence to assess how different policy approaches perform under real-world fiscal, workforce, and administrative constraints. Because the strength and type of available evidence varies across models, findings were weighed based on relevance to Maryland's context, consistency across sources, and demonstrated outcomes in comparable

jurisdictions. This approach allows the analysis to surface tradeoffs among effectiveness, equity, and feasibility, providing a transparent basis for the comparative discussion that follows.

Risk:

There are numerous risks that are encountered by both patients and providers. In Maryland, specifically, the state runs the risk of its program not having enough space to serve the population, with all 24 counties flagged as at-risk by the state, with 17 receiving funding and 5 just being added to the at-risk list. The state does not have the staff capacity to efficiently serve home-visiting clients. This is challenging with the diverse population of Maryland, and each county has a different composition. Data collection is challenging as it is fragmented between counties. Maryland parents do not know about the programs and have a lack of information about them. Maryland lacks a standard to judge the home visiting programs with appropriate accommodations to geography and location. (Maryland's Maternal, Infant, and Early Childhood Home Visiting Program, 2025) For risk, there are also the factors of race and location, as Black mothers were observed with higher rates of Hypertension. Maryland has issues with funding for the current workforce, as 54.5% of the workforce that left the Maryland home visiting program cited seeking higher pay elsewhere. (the Maryland Children's Cabinet, 2021)

Trends:

Nationally, the trends of effective home visiting programs show that 48% reduction in child abuse and neglect (Casey Family Program, 2022). Trends also show an improvement in cost-effectiveness when home visiting programs are implemented early, as in a study, it is found that early implementation is equal to $9,617 quality-adjusted life years with a 95% confidence level(Journal of Health Care for the Poor and Underserved, Volume 28, Number 4). 39% fewer Child Protective Services investigations for suspected child abuse and neglect. Families assigned

to FC also had a 33% decrease in total child emergency medical care use(JAMA Open Network, Vol. 4, No.7, 2021). For Trends in Maryland, 1% patients readmitted to E.R. with CC Fredrick, Family Connects Frederick County for kids and families. In 2023, 2,462 babies were born at Frederick Health Hospital, each of them eligible for Family Connects services, and 88% of them opted in for home visits(Fredrick Health 2023). In Maryland, 63% of the women aged 18-24 enrolled in their programs were disconnected from employment and school opportunities. This is a large increase from 54% in FY 2019. In FY 2021, a total of 50 staff turned over, representing 22% of the overall home visiting workforce (Maryland Children's Cabinet, 2021). 78 infants died suddenly from 2016 to 2018, with only 8 being natural deaths. 36 were sleeping-related, 16 accidental deaths, 13 homicides, and 5 undetermined. This shows the necessity for more prenatal care, safer sleeping environments for infants, and support for substance-exposed children. These are the suggestions from Baltimore City Fetal-Infant Mortality Review (FIMR) in their reviews of the deaths. According to Maternal and Child Mortality: Analysis of Nurse Home Visiting in 3 RCTs, "Nurse-visited women had lower external-cause mortality than their control group counterparts, with 'There was a marginally significant nurse home visiting−control difference in preventable-cause child mortality". The study shows that home visits by nurses for mothers and children in poverty may decrease premature death.

These outcomes demonstrate that when home visiting programs are implemented early and with coordinated supports, they produce measurable improvements in child safety, maternal health, and reduced emergency medical utilization. This indicates that strengthened delivery systems in Maryland could meaningfully reduce preventable harm.

Evidence Strength and Limitations:

Our analysis found that the strength of available evidence varies significantly across the

proposed alternatives, largely because most existing research focuses on nurse-led home visiting models, which were the client's initial priority. Across our literature review, at least 10 to 12 sources directly evaluate nurse home visiting programs, including randomized trials, statewide evaluations, and cost-effectiveness studies. In contrast, far fewer sources exist for the other alternatives. Only two sources provide empirical data relevant to Community Health Worker (CHW) led home visiting, and these tend to assess CHW models broadly rather than postpartum home visiting specifically. For geographically targeted expansions, we identified two to three sources, most of which examine disparities rather than evaluate targeted service design. As was previously alluded to, research on PATTY Centers is even more limited, with only one source from the Maryland State Department of Education offering descriptive information and no rigorous evaluations of their impact on maternal or newborn outcomes. Similarly, Social Impact Bonds (SIBs) have been used for this type of work in only one state, providing one source relevant to the feasibility of SIB financing for maternal and child health. Additional primary research, especially state-level evaluations and implementation data, will be necessary for Maryland to fully assess the cost, scalability, and impact of these emerging models. The uneven strength of available evidence underscores the importance of piloting complementary models to generate Maryland-specific data before scaling toward a universal framework.

These findings guided the development of the following policy recommendations, which prioritize models that address the state’s highest risks, build on existing strengths, and respond directly to the limitations revealed in the data.

Recommendations

In assessing policy alternatives for Maryland, we evaluated each approach based on four criteria:

1) equity impact and ability to reduce racial and geographic disparities, 2) scalability and feasibility within Maryland's current workforce capacity, 3) cost effectiveness and sustainability in a constrained fiscal environment, and 4) alignment with existing infrastructure and legislative momentum. These criteria helped determine which strategies should be pursued first and which require longer-term planning or additional data.

Center recommendations in Maryland's current fiscal reality

As Maryland considers how to strengthen maternal and newborn health outcomes, any set of recommendations must begin with a clear understanding of the state's fiscal and operational constraints. Maryland is entering a period of budget contraction and multi-year funding gaps that will make large new entitlements difficult to sustain. In this context, the state should prioritize approaches that are scalable, cost-efficient, and capable of leveraging existing infrastructure instead of creating entirely new systems. While the data shows that universal nurse home visiting programs remain one of the most effective models, it is also the most expensive and would likely require broader universal health reforms – such as expanded Medicaid reimbursement pathways and long-term workforce pipeline investments – before it becomes a feasible alternative. Given these constraints, Maryland Commission for Women (MCW) should advocate that the General Assembly take a sequenced approach: first, stabilize and strengthen Maryland's existing home visiting system, and then explore more expansive universal models as part of a longer-term maternal health strategy.

Strengthen and stabilize Maryland's current home visiting system

Maryland should also look to strengthen the foundation of its existing home visiting system by investing in workforce retention through competitive compensation, clear career ladders, and

tuition reimbursement pathways, especially given the 22% turnover reported in state-funded programs and the resulting strain on service delivery. Improving data standardization and interoperability across counties is equally important, as inconsistent systems create fragmentation and limit the state's ability to coordinate care effectively. To enhance oversight and guide more equitable resource allocation, MCW should advocate that Maryland develop a statewide performance and equity dashboard that tracks outcomes and access by race, geography, and program model. This would give policymakers clearer insight into where gaps persist and where they ought to be targeting investment for the greatest impact.

Advance a phased universal approach by piloting the lower-cost alternatives

Expand Maternal Support Centers: As Maryland works to stabilize and enhance its existing home visiting infrastructure, a complementary next step is to expand the role of existing PATTY Centers as accessible hubs for postpartum support. These centers are already trusted access points for families and are well equipped to offer drop-in services such as lactation counseling, health education and care navigation – all resources that are especially valuable for families who decline or are unable to participate in home visiting. Expanding hours, staffing, and program offerings would allow PATTY centers to broaden their reach while easing pressure on existing or subsequent home visiting workforces. Because they build on existing facilities and administrative capacity, scaling these centers represents a comparatively low-cost strategy for strengthening Maryland's maternal health continuum. This will ensure that new parents can access support in multiple ways.

Pilot a Community Health Worker Home Visiting Model: To begin expanding reach in a cost-effective way, MCW should advocate for Maryland to pilot a Community Health Worker

(CHW) home visiting model that offers universal postpartum visits for all new parents. CHWs provide a lower-cost, workforce flexible option that can help close service gaps without adding pressure to the already limited supply of nurses for a full nurse home visiting option. A CHW-led model also supports equity goals, as CHWs are often more deeply-rooted in the communities they serve. They can build trust with families who may be hesitant to engage with traditional healthcare systems. Developing Maryland-specific CHW certifications focused on maternal and infant health competencies would ensure a consistent standard of care across jurisdictions while creating a clear professional pathway for this workforce. A statewide pilot would allow Maryland to test the model's effectiveness, understand its operational needs and assess how a CHW tier could integrate with existing nurse-led programs before considering broader implementation.

Consider Social Impact Bonds for Targeted Expansion: Social Impact Bonds (SIBs) are a form of performance-based financing in which private or philanthropic investors fund program delivery upfront, and the state repays those investors only if agreed-upon outcomes are achieved. This structure reduces fiscal risk while enabling the expansion of evidence-based services, making SIBs a potentially useful tool for Maryland in a constrained budget environment. South Carolina's statewide Nurse-Family Partnership SIB illustrates how this approach can extend access to services for thousands of first-time, Medicaid-eligible mothers who otherwise would not be reached, while tying state payments directly to verified outcomes such as healthier births and reductions in emergency medical use (South Carolina Department of Health and Human Services). The Social Finance interim assessment also highlights operational benefits, including strengthened data systems, clearer performance metrics, and more disciplined collaboration across state agencies, evaluators, and frontline providers. These features enabled South Carolina

to monitor program fidelity in real time and keep expansion efforts aligned with measurable impacts (Social Finance).

While SIBs are not well suited to financing a fully universal home visiting system, they offer Maryland a strategic mechanism for piloting targeted expansion in high-need areas. MCW could advocate for the use of SIBs to support limited-scale implementation that builds data capacity and rigorously evaluates equity impacts before the state commits to long-term appropriations.

Build toward universal newborn support through integrated policy reforms

Maryland will need to pair near-term expansion with broader structural reforms that make long-term implementation possible. Universal models cannot fully succeed without addressing upstream barriers. These issues currently limit capacity and access. This includes persistent nurse workforce shortages, reimbursement restrictions for postpartum and home visiting services, and the fragmentation that exists between health systems, Medicaid, and community-based providers. These constraints create gaps in follow-up care and weaken coordination, making it difficult for families to navigate services even when programs exist in their communities. To ensure that any move toward universal newborn support is both sustainable and equitable, MCW should support a multi-year legislative agenda that strengthens the underlying health infrastructure while incrementally expanding access. Aligning program growth with universal health reforms would make future investments in maternal and newborn health more durable and prevent overextension of the workforce, while also positioning Maryland to scale evidence-based models statewide down the road.

Prioritize equity by embedding racial and geographic targeting

Equity must be a guiding principle in every recommendation. Any expansion should be directed toward the regions and populations experiencing the highest maternal and infant mortality. Programs should also adopt standardized screening tools and coordinated referral systems to limit structural bias and ensure that families with the greatest need are identified early. This includes reducing practical barriers such as transportation constraints in rural and underserved areas, where distance to care and limited transit can prevent timely postpartum follow-up and disconnect families from essential supports. Ensuring that services are delivered in ways that meet families where they are – whether in homes, community hubs, or flexible access points – helps eliminate these access gaps. Ongoing consultation with Black maternal health organizations, rural health partners, and other key community stakeholders will be essential. Their insight can help the state stay grounded in the lived realities driving disparities and ensure that equity remains central as Maryland's system evolves.

Reach toward universal nurse home visiting coverage

As Maryland evaluates long-term strategies to improve maternal and newborn health, universal nurse home visiting should remain an aspirational but achievable goal. Universal models have several advantages over targeted programs: they reduce stigma, ensure that all families receive at least one postpartum assessment, and create a predictable, standardized point of contact that can reveal urgent needs early. States that have implemented or piloted universal home visiting demonstrate that offering services to every family, regardless of risk level, improves participation rates, strengthens continuity with existing healthcare systems, and reduces racial and geographic disparities in postpartum outcomes. For Maryland, advancing toward a universal framework would meaningfully complement its broader goals of equity and early intervention.

Reaching this goal, however, requires addressing foundational constraints. Universal programs demand a stable and sizable nursing workforce, yet Maryland faces shortages that would require multi-year investments in recruitment, retention, and training pipelines. The state would also need sustainable reimbursement mechanisms to offset the higher costs of nurse-delivered services. Expanding postpartum billing options through Medicaid, developing dedicated state allocations, and coordinating with private insurers would create a diversified funding base capable of supporting long-term adoption. In addition, universal home visiting succeeds only within systems that are well coordinated; Maryland will need data-sharing agreements, common referral pathways, and alignment across hospitals, local health departments, Medicaid, and community providers to ensure that families do not fall through gaps in the system.

The legislative workgroup established under SB 156/HB 334 remains the best vehicle for guiding this long-term planning. Its charge should extend beyond cost estimation to include modeling different implementation timelines, evaluating hybrid workforce structures, identifying necessary regulatory changes, and assessing how universal home visiting would interface with parallel reforms in behavioral health, early childhood education, and Medicaid coverage. The workgroup should also solicit input from hospital systems, nurse educators, community health experts, doulas, and maternal health advocates to ensure the model reflects on-the-ground realities.

By framing universal nurse home visiting as a phased, multi-year initiative rather than an immediate mandate, Maryland can build capacity while preserving fiscal responsibility. Strengthening the existing system, expanding alternative models, and testing scalable innovations through CHW pilots or targeted SIB-financed expansions will give the state the infrastructure needed to support a universal approach. When pursued deliberately, universal

home visiting can serve as the backbone of a comprehensive postpartum care strategy.

Conclusion

The evidence reviewed in this report demonstrates that Maryland's maternal and newborn health disparities are driven not by a lack of effective interventions, but by fragmented infrastructure, workforce instability, and uneven access across geography and race. Together, these findings support a sequenced policy response that prioritizes stabilizing existing home visiting programs, expands lower-cost and complementary access points, and uses targeted financing tools to test scalable approaches before pursuing universal coverage.

Maryland has taken meaningful steps toward improving maternal and newborn health. However, persistent racial and geographic disparities make clear that current efforts are insufficient. Families across the state still face barriers to accessing timely postpartum support, and gaps in coordination, data sharing, and workforce capacity limit the reach and effectiveness of existing programs. These conditions place the greatest burden on Black mothers and rural communities, reinforcing longstanding inequities and undermining the health and stability of new families.

The policy alternatives evaluated in this report demonstrate that Maryland has multiple viable paths to expand support in the early postpartum period. Strengthening the state's existing home visiting infrastructure, investing in workforce retention and data standardization, and expanding the role of existing maternal support centers offer immediate opportunities to improve care delivery within the current fiscal landscape. Strategic pilots – such as Community Health Worker-led home visiting and performance-based financing through Social Impact Bonds – can help the state evaluate cost and scalability, while prioritizing equity impact and building capacity for broader implementation.

Momentum toward universal nurse home visiting presents Maryland with a powerful long-term

vision: a system in which every new family receives support at a pivotal moment that influences lifelong outcomes. Achieving this goal will require investment, sustained legislative leadership, and ongoing collaboration with community partners. By pursuing the recommendations outlined in this report, the Maryland Commission for Women and state policymakers can advance an equitable postpartum care strategy that improves access, strengthens mother and infant wellbeing, and ensures healthier starts for all of Maryland's children.

Works Cited

Baltimore City Health Department. *January 2020 FIMR/CFR Recommendations.* Baltimore City Health Department, 2020, https://www.healthybabiesbaltimore.com/_files/ugd/6a76e9_61d0ba7a4b2b4aaca52e2fe572c9605e.pdf.

Casey Family Programs. *Home Visiting Programs: Return on Investment.* Casey Family Programs, 2022, https://www.casey.org/home-visiting-programs/.

Condon, Elizabeth M., et al. "Maternal, Infant, and Early Childhood Home Visiting: A Call for a Paradigm Shift in States' Approaches to Funding." *Maternal and Child Health Journal*, vol. 23, no. 3, 2019, pp. 374–81. PubMed Central, https://pmc.ncbi.nlm.nih.gov/articles/PMC6600820/.

Corso, Phaedra S., Justin B. Ingels, and Rebecca L. Walcott. *Costs of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Evaluation.* OPRE Report 2022-01, Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2022.

Donelan-McCall, N. S., M. D. Knudtson, and D. L. Olds. "Maternal and Child Mortality: Analysis of Nurse Home Visiting in 3 RCTs." *American Journal of Preventive Medicine*, vol. 61, no. 4, Oct. 2021, pp. 483–91. https://doi.org/10.1016/j.amepre.2021.04.014.

Frederick Health. *Community Impact Report 2023.* Frederick Health, 2023, https://www.frederickhealth.org/documents/community/Community_Impact_Report_2023.pdf.

Goodman, W. B., K. A. Dodge, Y. Bai, R. A. Murphy, and K. O'Donnell. "Effect of a Universal Postpartum Nurse Home Visiting Program on Child Maltreatment and Emergency Medical Care at 5 Years of Age: A Randomized Clinical Trial." *JAMA Network Open*, 2021, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2781681.

Maryland Children's Cabinet. *Report on the Implementation and Outcomes of State-Funded Home Visiting Programs in Maryland,* 2021, https://dlslibrary.state.md.us/publications/Exec/GOCPYVS/HU8-507(c)_2021.pdf.

Maryland Department of Health. *Maryland's Maternal, Infant, and Early Childhood Home Visiting Program: Statewide Needs Assessment Update.* 12 Mar. 2025, https://health.maryland.gov/phpa/mch/Documents/HV/Maryland-MIECHV-Needs-Assessment-Update_May2025.pdf.

Maryland Department of Health. *Women's Health Strategy Brief.* Maryland Department of Health, May 2024, https://health.maryland.gov/phpa/mch/Documents/Women%27s%20Health/Womens%20Action%20Plan/2405_PHA_WomensHealthStrategy_Brief.pdf.

Maryland General Assembly. *Senate Bill 156 / House Bill 334: Universal Newborn Nurse Home Visiting Services and Workgroup Establishment.* Chapter 720, 2025, https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/SB0156.

"South Carolina DHHS Launches First Statewide Pay for Success Initiative." *South Carolina Department of Health and Human Services*, 2016, https://www.scdhhs.gov/press-release/south-carolina-dhhs-launches-first-statewide-pay-success-initiative

South Carolina Nurse-Family Partnership Social Impact Bond: Interim Project Assessment. Social Finance, 2021, https://socialfinance.org/insight/south-carolina-nurse-family-partnership-social-impact-bond-interim-project-assessment/

Stierman, Elizabeth K., et al. "Educating Families on Urgent Maternal Warning Signs: Learning from a Pilot to Improve Training and Tools for Maternal and Child Home Visiting Programs." *Health Promotion Practice,* vol. 26, no. 4, 2025, pp. 772–784.

Wu, Jinjing, et al. "The Cost-Effectiveness Analysis of Nurse-Family Partnership in the United States." *Journal of Health Care for the Poor and Underserved,* vol. 28, no. 4, 2017, pp. 1578–97. https://doi.org/10.1353/hpu.2017.0134.

Maryland State Department of Education. "Patty Centers/Family Support Center Network." *Division of Early Childhood*, earlychildhood.marylandpublicschools.org/families/patty-centersfamily-support-center-network.