Maternal & Infant Health Assessment Prince George's County 2025

Prepared for the Board of Health
By Dr. Diane J Young, Dr. Kristen Newman and Jacob Riley
Prince George's County Health Department

Introduction

This report responds to the Board's commission for a comprehensive evaluation of maternal and infant health in Prince George's County. The dual objectives are: (1) to systematically identify the structural and programmatic gaps that drive maternal and infant health disparities, and (2) to advance evidence-informed, equity-centered strategies grounded in both theory and data that strengthen the County's role as chief health strategist.

Persistent disparities in outcomes, particularly among non-Hispanic Black women demand rigorous, data-driven solutions that are academically defensible and operationally sustainable. The recommendations herein integrate a critical equity framework, Representation, Opportunity, Belonging (ROB) and align with national best practices from HRSA, CityMatCH, AMCHP, and peer-reviewed maternal health research.

Background and Need

Maternal mortality and severe maternal morbidity (SMM) are urgent public health concerns across the United States. Black women remain three to four times more likely to die from pregnancy-related causes compared with White women, a disparity that persists regardless of income or education (CDC, 2023). In Maryland, maternal mortality ratios remain higher than the national average, with Prince George's County disproportionately affected due to social determinants of health, structural inequities, and gaps in continuity of care.

At the same time, infant mortality, low birth weight, and preterm birth remain persistent challenges (Table 1). Breastfeeding initiation and duration, though improving, still lag national targets, and perinatal mental health remains underdiagnosed and undertreated. These outcomes are influenced by systemic barriers: lack of access to culturally competent care, insufficient insurance coverage, and inadequate integration of clinical and community health supports. Locally these issues are prominent enough to warrant inclusion of Women's Health as one of the top 5 priorities in the 2024 Maryland State Health Improvement Plan (SHIP) and Maternal and Infant health in the Prince George's County 2025 Community Health Assessment (CHA)

Against this backdrop, Prince George's County has invested in promising strategies, including maternal and child health care coordination through Healthy Beginnings,

expanded hours in designated programs, mobile vaccination clinics, perinatal hypertension management with postpartum three-day follow-up, and a new ombudsman role in Family Health Services. However, without scaling evidence-based models, embedding equity frameworks such as Representation, Opportunity, and Belonging (ROB), and addressing structural barriers such as financing and workforce development, the County risks perpetuating fragmented systems that fail to close persistent gaps.

Epidemiological Landscape

National data confirms that the United States continues to face a maternal health crisis. In 2023, the U.S. maternal mortality rate was 18.6 per 100,000 live births down from 22.3 in 2022 but with rates exceeding 50 per 100,000 for Black women compared to approximately 14.5 for non-Hispanic White women CDCAP News.

Additionally, between 2018 and 2022, pregnancy-related deaths surged by nearly 28 percent, with a disproportionately high burden among Black, Native American, and Alaska Native populations New York Post. Alarmingly, over half of maternal deaths now occur postpartum, signaling critical transition gaps between obstetric and primary care (Commonwealth Fund 2021)

These disparities are not merely statistical, they reflect the intersections of systemic racism, unequal access to care, and sociopolitical neglect.

Determinants of Disparities

Research underscores the role of socio-environmental vulnerabilities—including limited care access, provider bias, lack of postpartum support, and social determinants—in fueling inequities Reuters. A national workshop convened by the National Academies emphasized system-level quality improvement, patient stratification, and structural interventions as essential components of a maternal health equity response (National Academies Press 2021) (National Academies Press 2024)

These findings are further supported with local data. The Community Resident Survey, conducted as part of the 2025 CHA, found that gynecology/obstetrics was the second most common type of specialty care residents reported being unable to access in the past year. The top barriers reported in accessing healthcare were availability of appointments, time limitations, availability of providers, and lack of money for co-pays/prescriptions (2025 Community Health Assessment.pdf)

Current Services: Health Department Programs

The Health Department oversees a suite of programs addressing reproductive, maternal, and infant health:

- **Healthy Beginnings**: A state-funded, locally developed home-visiting model providing care coordination, safe sleep education and cribs, hypertension monitoring, and three-day postpartum follow-up. Identified herein as a "promising practice" with potential for alignment with MIECHV evidence-based criteria.
- **Reproductive Health Resource Centers (Cheverly)**: Offers Well woman care, Family planning, reproductive health services, and STI management.
- **The Maternal and Child Health Center @Laurel**: Offers pediatric and adolescent health services including well child health care visits, sick visits, childhood vaccinations, sport physicals and other confidential services.
- **PREP (Personal Responsibility Education Program)**: Offers adolescent reproductive and life-skills education.
- **WIC and Breastfeeding Support**: Nutrition supplementation and lactation services.
- **Vaccine for Children (VFC)**: Ensures immunization access for uninsured and underinsured children.
- **HIV Clinic & Ryan White Services**: Includes perinatal prevention of transmission.
- **Dental Clinic**: Provides oral health services for women and children.
- **Health Assures:** Historically designed as a reimbursement program for Federally Qualified Health Centers serving uninsured residents, is undergoing reform. Plans for FY26 include transitioning to a per-member, per-month (PMPM) model by FY27. This transition aligns financing with accountability, reduces per-visit reimbursement rates, and allows for performance-based monitoring of outcomes.

Some key structural supports include the Child Fatality Review Team (CFR), mandated under COMAR, while FIMR (Fetal and Infant Mortality Review) and its associated Community Action Team (CAT) are nationally recommended, voluntary review models.

Partner Ecosystem

Coordination with medical systems including Kaiser Permanente, MedStar Southern Maryland Hospital, University of Maryland Capital Regional Health Centers, local FQHCs, Department of Family Services, Department of Social Services, Department of Corrections, academic partners including Prince Georges County Public Schools, University of Maryland College Park: School of Public Health, George Washington University: The Milken Institute School of Public Health, Bowie State University, Prince George's Community College and data exchange infrastructure Chesapeake Regional Information System for our Patients (CRISP) creates a robust network though integration remains uneven. Non-traditional partners such as pharmacies, private schools, and faith-based organizations are underutilized in maternal health outreach and care coordination.

The Community Health Improvement Plan (CHIP), conducted following the 2025 CHA, will be one opportunity to strengthen current and build new partnerships with agencies throughout the County. With an anticipated completion date of July 2026, the CHIP is a systematic process centered around community collaboration. The end result is a 3-to-5-year plan that outlines key strategies, coordinates actions between partners, and targets necessary resources to address the health priorities identified in the CHA.

Gaps and Unmet Needs

Critical gaps persist:

- **Mental Health**: Perinatal depression and anxiety screening and treatment are minimally integrated, despite 1 in 5 mothers experiencing these disorders and associated negative outcomes Verywell FamilyCommonwealth Fund.
- **Doula Access**: No formal doula service structure, despite strong evidence of benefits in improving delivery outcomes and maternal satisfaction.
- **Transportation**: Lack of systematic support despite known barriers to care continuity.
- **Postpartum Care Continuity**: Insufficient mechanisms for postpartum follow-up, especially in the crucial "fourth trimester."
- **Evidence for Local Programs**: Healthy Beginnings remains a promising practice but lacks the infrastructure to achieve evidence-based recognition.
- **Data Infrastructure**: Surveillance systems lack equity stratification and cross-sector interoperability.

Recommendations

1. **Expand and Strengthen Home Visiting Services (e.g., MIECHV, Nurse-Family Partnership)**

Rationale & Evidence

Evidence-based home visiting is among the most rigorously evaluated maternal and child health interventions. The Nurse-Family Partnership (NFP), for instance, has demonstrated significant reductions in preterm births, maternal hypertension, and child abuse, alongside improvements in economic self-sufficiency. Independent cost-benefit analyses show a societal return of $5.70 per $1 invested, underscoring its fiscal as well as health impact (Commonwealth Fund, 2020). Similarly, the federally funded Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program has been recognized for advancing health equity by targeting high-risk families with home-based education, case management, and developmental support (HRSA, 2023). Expanding and increasing the number of early

childhood home visiting programs is also a strategy identified in the Maryland SHIP aimed at reducing the rates of preterm births, infant mortality, and babies born with low birth weight.

Local Application

Prince George's County's Healthy Beginnings program, currently a promising practice funded by the Maryland Department of Health, already provides care coordination, safe sleep education (crib distribution), hypertension management, and postpartum follow-up. However, it does not yet meet the federal criteria for an evidence-based model. To evolve into an evidence-based program, Healthy Beginnings should align with MIECHV-approved curricula (e.g., NFP, Parents as Teachers, or Healthy Families America) and establish rigorous evaluation partnerships with universities. Enrollment should be targeted to ZIP codes with the highest infant mortality and severe maternal morbidity, ensuring equity-driven impact. Until fully aligned, Healthy Beginnings should be formally recognized as a "promising practice" with a pathway toward evidence-based designation.

2. **Implement Evidence-Based Safety Bundles via Perinatal Quality Collaboratives (PQC/AIM)**

Rationale & Evidence

The Alliance for Innovation on Maternal Health (AIM**)**, in partnership with state Perinatal Quality Collaboratives (PQCs), has developed standardized safety "bundles" for leading drivers of maternal morbidity and mortality (e.g., hypertension, hemorrhage, cesarean reduction, perinatal mental health). Peer-reviewed studies show that implementation of AIM bundles significantly reduces preventable complications and narrows racial disparities (Howell et al., 2018, *Obstetrics & Gynecology*). The CDC, AMCHP, and Medicaid programs strongly endorse bundle implementation as a national best practice.

Local Application

Prince George's County should partner with Maryland's PQC to ensure all county hospitals adopt and sustain AIM bundles. Where hospitals are already implementing bundles, the County can serve as a convener, aligning community-based programs (Healthy Beginnings, doulas, WIC) with hospital protocols to ensure continuity of care. A county-level Maternal Health Safety Learning Collaborative could further institutionalize these practices across clinical and community settings. Introducing AIM bundles with providers to address maternal/postpartum hemorrhage and hypertension is another strategy identified in the Maryland SHIP. Aligning local efforts with state goals provides opportunities to collaborate with partners outside of the County and to potentially secure additional funding or other support.

3. Promote Breastfeeding and Baby-Friendly Practices

Rationale & Evidence

The Baby-Friendly Hospital Initiative (BFHI), supported by WHO and UNICEF, requires hospitals to adopt ten evidence-based steps that promote breastfeeding (skin-to-skin contact, rooming-in, formula restriction, lactation support). BFHI accreditation correlates with significantly higher breastfeeding initiation and continuation rates (Centers for Disease Control and Prevention, 2022). Breastfeeding is associated with reductions in infant infections, maternal breast cancer risk, and obesity prevention.

Local Application

Prince George's County should incentivize local birthing hospitals to seek BFHI accreditation and expand breastfeeding support through WIC, which has already demonstrated strong performance in improving breastfeeding initiation and duration. County-wide infant feeding policies should align with BFHI standards, embedding consistent messaging across RHRC, MCH at Laurel, and Healthy Beginnings.

4. Address Social Determinants through Direct Support and Cash Transfer Pilot Programs

Rationale & Evidence

Growing evidence demonstrates the effectiveness of unconditional cash transfers in improving maternal and infant outcomes. Michigan's Rx Kids pilot provides cash support to every pregnant person and infant in Flint, with goals of reducing poverty-related stress and improving maternal mental health and nutrition. International studies of programs like GiveDirectly have similarly found that direct support improves prenatal care adherence and infant survival (American Hospital Association, 2023; Washington Post, 2024).

Local Application

Prince George's County could collaborate with philanthropic and private partners to pilot a targeted pregnancy/postpartum cash support initiative, focusing on individuals experiencing housing insecurity, food insecurity, or unemployment. Evaluation should be embedded from the outset to determine impact on maternal engagement with prenatal care, stress reduction, and infant health outcomes.

5. Invest in Culturally Competent Community-Based Perinatal Care (Doulas and Midwives)

Rationale & Evidence

Doulas and midwives provide culturally congruent, non-clinical perinatal support that has been shown to reduce cesarean rates, increase breastfeeding initiation, and improve patient satisfaction (Bohren et al., 2019, *Cochrane Review*). Models such as Jennie

Joseph's "JJ Way" (Common Sense Birth Inc. 2025) highlight the effectiveness of community-based midwifery and respectful maternity care in reducing disparities. The Maryland SHIP identified increasing access to doulas and midwives across the state as a key strategy to reducing maternal mortality rates.

Local Application (with ROB Framework)
Prince George's County has an opportunity to lead nationally by embedding **Representation, Opportunity, and Belonging (ROB)** into doula workforce development. This framework reimagines equity efforts beyond DEI by emphasizing structural inclusion (representation of diverse doulas), equitable pathways to certification and reimbursement (opportunity), and integration of doulas into clinical and community perinatal systems (belonging).
The County should consider the way forward to:

- Establish a **county-level registry of doulas** with credentialing pathways tied to Medicaid and commercial reimbursement.
- Collaborate with the **U.S. Department of Labor** to formally classify doulas as a labor category within the Standard Occupational Classification (SOC) system, ensuring long-term sustainability and workforce protections.
- Fund local doula training pipelines, prioritizing candidates from historically excluded communities.

6. **Create Integrated Postpartum Programs (e.g., Cardiovascular Follow-Up)**

Rationale & Evidence

Cardiovascular disease is the leading cause of maternal mortality in the United States, with risks extending well into the postpartum period (CDC, 2023). Programs such as Bridgeport Hospital's Postpartum Heart Care Program integrate structured cardiovascular follow-up and transition to primary care, reducing readmissions and improving blood pressure control in Medicaid and uninsured populations (Hameed et al., 2021, *Journal of the American College of Cardiology*). These interventions are consistent with AIM's Severe Hypertension in Pregnancy bundle and have been endorsed by the American Heart Association as essential components of maternal safety.

Local Application
Prince George's County should build a postpartum cardiovascular care pathway that integrates into its RHRC Cheverly, MCH at Laurel, and FQHC partners. All birthing individuals with hypertensive disorders should be enrolled into a structured three-day postpartum blood pressure check, with extended follow-up at 6 weeks and 12 weeks.

Embedding care coordination within Healthy Beginnings will ensure continuity. Additionally, linkage agreements with cardiology practices should be established for escalated care.

7. Strengthen Maternal Care Access in Maternity-Care "Deserts" via Telehealth and Incentives

Rationale & Evidence

According to the March of Dimes 2022 Report on Maternity Care Deserts, more than 2.2 million women of childbearing age live in counties with no hospital offering obstetric services. Lack of access contributes to late prenatal care initiation and adverse birth outcomes, especially among Black, Hispanic and rural populations. In Prince George's County the % of births to mothers who received late or no prenatal care was 11.5%, compared to the state average of 7.4%. The rate among Black women in the County was 9.2% compared to the state rate of 8.5%. The rate for Hispanic mothers of any race is 15.8% in the County, compared to 13.5% statewide.

Evidence supports the use of telehealth for prenatal care, particularly hybrid models combining in-person and remote visits, which have shown equivalent safety outcomes (Butler Tobah et al., 2019, *Obstetrics & Gynecology*). Incentive programs to attract obstetric providers to underserved areas have also demonstrated effectiveness (HRSA, 2022).

Local Application

While Prince George's County is not a full maternity care desert, access gaps exist in Laurel and southern parts of the County. The Health Department should map prenatal service gaps, expand mobile perinatal clinics, and deploy telehealth prenatal services through FQHCs and community-based settings. The County should also explore loan repayment or housing stipends to incentivize obstetric providers to practice in underserved zones.

8. Institutionalize Equity in Maternal Health via Policy and Systems Reform

Rationale & Evidence

Persistent racial disparities in maternal outcomes are driven by systemic inequities and implicit bias in care. The American Hospital Association (2022) emphasizes that sustainable reform requires embedding equity into institutional policy, not just clinical training. Interventions such as mandatory anti-bias training, maternal mortality review committees, and equity-focused quality improvement have been linked to reductions in racial gaps in maternal outcomes (Howell et al., 2020, *Health Affairs*). This is yet another area of synergy with the Maryland SHIP, which identified increasing the number of health care providers receiving implicit bias training as an important step to improving rates of prenatal care and reducing maternal mortality.

Local Application
Prince George's County should formally adopt the ROB (Representation, Opportunity, Belonging) framework as a replacement for DEI in maternal health equity strategy. This will ensure visible representation in workforce and decision-making, equitable advancement pathways for maternal health professionals, and environments where community voices are central to policy development. Equity requirements should be embedded in all provider contracts, and the County should establish a Maternal Equity Oversight Committee aligned with Title V and HRSA guidance.

9. Improve Data Integration and Surveillance for Comprehensive Needs Assessment

Rationale & Evidence
Fragmented data systems limit the ability to monitor maternal health outcomes effectively. The Commonwealth Fund (2022) identifies comprehensive data integration including preconception services, rapid pregnancy identification, case management, oral health, and nutrition—as critical to high-performing maternal health systems. Health IT innovations, including pregnancy status alerts and postpartum follow-up tracking, are endorsed by HealthIT.gov's Maternal Health IT Toolkit.

Local Application
Prince George's County should work with CRISP (Maryland's Health Information Exchange and DC) to embed pregnancy and postpartum flags into EHR systems. The County can also create a Maternal & Infant Health Dashboard that integrates RHRC, MCH Laurel, WIC, and FQHC data. This system will allow for real-time surveillance of severe maternal morbidity, infant mortality, breastfeeding rates, and postpartum follow-up.

10. Foster Peer Learning and Workforce Capacity via National Affiliations

Rationale & Evidence
Participation in national learning networks accelerates adoption of best practices and expands workforce capacity. The Association of Maternal and Child Health Programs (AMCHP) provides technical assistance, policy guidance, and peer-to-peer learning. CityMatCH, a national MCH leadership network, equips local health departments with training and data tools to advance maternal health equity. Similarly, the National Governors Association (NGA) supports state-level MCH workforce initiatives that can be adapted for local jurisdictions. Evidence shows that active participation in such networks improves program sustainability and innovation (AMCHP, 2021).

Local Application
Prince George's County should deepen its engagement with AMCHP, CityMatCH, and NGA, leveraging their toolkits, learning collaboratives, and leadership development

opportunities. The County should designate staff for active participation and pursue technical assistance grants to build local workforce capacity. This investment will ensure Prince George's County remains aligned with national best practices while scaling its own innovative models like Healthy Beginnings and the ROB-informed Doula framework.

Prince George's County Health Department Leadership in Action:
Prince George's County Postpartum Collaboration Extension (Maternal Health)

Rationale and Evidence
Postpartum complications, especially hypertension and cardiovascular conditions, are leading causes of severe maternal morbidity and preventable maternal mortality in Maryland and nationally. Early intervention through home visits, telehealth monitoring, and culturally responsive support has been shown to significantly reduce readmissions, improve continuity of care, and strengthen engagement in behavioral health services. Programs like Nurse-Family Partnership and emerging hospital-based cardiovascular postpartum models (e.g., Bridgeport Hospital Postpartum Heart Care Program) demonstrate measurable reductions in adverse outcomes.

The need for this is evidenced locally in the high rates of ED utilization (19,424 visits in 2022) for complications of pregnancy; childbirth and postpartum (Figure 1). Additionally, complications of pregnancy; childbirth and postpartum is the leading principal diagnosis for hospitalizations in Prince George's County, closely followed by low birth weight, birth trauma, perinatal infections, and other conditions of the perinatal period (Figure 2).

Local Application
Prince George's County is expanding its perinatal hypertension program in FY26 that targets birthing individuals at highest risk for severe maternal morbidity, including those with hypertensive disorders and cardiovascular conditions. The initiative integrates:

- **Nurse-led home visits and telehealth assessments** within 3 days of discharge.
- **Culturally responsive doula and CHW support**, grounded in the **Representation, Opportunity, and Belonging (ROB) Framework**.
- **Standardized depression screening** (EPDS, PHQ-9) with behavioral health referrals.
- **Epic/CRISP-enabled tracking** for early detection and continuity of care.
- **Equity dashboards in Power BI** to disaggregate outcomes by geography, race, and insurance status.
- **Stakeholder convenings** with Medicaid MCOs, MDH, and commercial payers to explore sustainable financing (e.g., Section 1115 Waiver, State Plan Amendment, commercial coverage mandates).

SMARTIE Goals

- Reduce 30-day postpartum readmissions among hypertensive clients by 15% by June 2026.
- Achieve 85% postpartum RN follow-up (home or telehealth) within 3 days of discharge.
- Ensure 100% of CHWs/doulas engaged are Prince George's County residents who reflect the cultural and linguistic diversity of the community.

Program Evaluation

The program will apply a dual RE-AIM and ROB framework to ensure both operational rigor and equity-centered outcomes. This integrated approach enables the Health Department to monitor program performance and patient impact through established evaluation metrics, while embedding the principles of Representation, Opportunity, and Belonging (ROB) across all domains.

Evaluation Infrastructure: Outcomes will be tracked using Epic, CRISP, and Power BI dashboards, allowing near–real-time monitoring of service delivery and clinical indicators. Findings will be reviewed quarterly by internal leadership and consolidated into a comprehensive year-end report in June 2026.

Evaluation Methodology: RE-AIM Integrated with ROB

The program evaluation will be guided by the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance) with equity lenses from the ROB framework to ensure that representation, opportunity, and belonging are embedded throughout. Together, these frameworks provide a structured method to assess clinical impact, operational feasibility, and cultural congruence, while ensuring sustainability and community trust.

RE-AIM Defined:

- **Reach:** Who is being served and who may be excluded?
- **Effectiveness:** What measurable impact does the program achieve?
- **Adoption:** Which providers and partners are delivering the interventions?
- **Implementation:** How consistently and effectively are protocols delivered?
- **Maintenance:** Can the program be sustained over time?

Application of the Evaluation Framework

The evaluation will employ a mixed-methods design, integrating quantitative measures with qualitative insights from clients, staff, and partners. This ensures both statistical rigor and contextual understanding.

- **Reach:** Track the number and percentage of eligible clients enrolled, stratified by geography, race/ethnicity, language, and insurance status to identify equity gaps in participation.
- **Effectiveness:** Measure key clinical and behavioral outcomes, including blood pressure control among hypertensive clients, Edinburgh Postnatal Depression Scale (EPDS) scores, breastfeeding initiation and duration, and reductions in severe maternal morbidity.
- **Adoption:** Assess the degree to which hospitals, Federally Qualified Health Centers, and community-based organizations incorporate program elements into routine workflows. Participation rates will be monitored to evaluate engagement across systems.
- **Implementation:** Evaluate fidelity to protocols, including timeliness, frequency, and type of client contact, as well as adherence to evidence-based bundles and curricula. Qualitative assessments (e.g., staff interviews, focus groups) will be used to capture barriers and facilitators.
- **Maintenance:** Examine long-term sustainability by assessing readiness for institutionalization, the stability of funding streams, and the level of policy or leadership support for scaling successful program components.

By pairing RE-AIM's structured evaluation domains with ROB's equity principles, this framework ensures that maternal and child health programs are not only effective and evidence-based but also inclusive, representative, and sustainable within Prince George's County.

Health Assures FY27 Redesign (Primary Care Access)

Background and Current Model

The Health Assures program was established to expand access to primary care for uninsured County residents through a per-visit reimbursement mechanism with Federally Qualified Health Centers (FQHCs). While the model successfully increased entry points to care and strengthened County-FQHC partnerships, it has not demonstrated long-term financial sustainability. The current $180 per-visit reimbursement structure prioritizes service volume without accountability for patient outcomes, population health impact, or equity advancement.

Strengths of the Current Model

- Provides uninsured residents with a reliable access point for primary care services.
- Reinforces long-standing collaborations between the County and FQHCs.
- Serves as a safety-net program during a period of increasing uninsured populations.

Challenges

- **Financial Unsustainability:** The per-visit reimbursement model places disproportionate fiscal risk on the County without mechanisms for cost containment.
- **Misaligned Incentives:** Paying per visit rewards higher utilization rather than incentivizing prevention, continuity, or improved health outcomes.
- **Lack of Oversight:** The absence of administrative infrastructure limits the County's ability to verify eligibility, track encounters, or enforce quality standards.
- **Gaps in Accountability:** No performance-informed contracting mechanisms exist, leaving the County unable to hold providers accountable for equity driven outcomes.

Future Direction and Redesign Plan

To achieve sustainability, improve accountability, and align with national best practices, Health Assures will undergo a two-phase redesign:

- **FY26: Program Redesign and Development Year**
    - Build administrative infrastructure, including staff positions for eligibility verification, budget analysis, quality assurance, and program management.
    - Develop a performance informed contracting framework with measurable outcomes (e.g., continuity of care, hypertension control, diabetes screening, and postpartum follow-up).
    - Establish robust data collection and reporting mechanisms through Epic and CRISP integration, enabling performance monitoring in near real time.
- **FY27: Transition to PMPM and Performance-Based Model**
    - Shift from per-visit reimbursement to a per-member-per-month (PMPM) payment structure, aligning with managed care and value-based purchasing models.
    - Gradually reduce and phase out the $180 per-visit reimbursement to incentivize prevention, coordination, and continuity of care rather than high visit counts.
    - Introduce performance informed contracts that tie a portion of PMPM payments to achieving measurable health outcomes, such as control of chronic disease and maternal health indicators.

Alignment with Maternal Health Priorities

Health Assures will directly align with the County's maternal health strategy by ensuring that uninsured birthing people receive postpartum follow-up, chronic disease

management (e.g., hypertension, diabetes), and continuity of care beyond the hospital setting. This integration will bridge maternal health initiatives with primary care, ensuring that uninsured mothers and infants are not lost to follow-up during a critical health window.

Broader Policy Context

Transitioning to a PMPM reimbursement structure reflects national best practices in primary care financing, reduces cost exposure for the County, and creates enforceable accountability for health outcomes. By embedding equity centered performance metrics, disaggregated by race, ethnicity, and geography. Health Assures can serve as both a safety-net access program and a driver of health equity.

Conclusion

Prince George's County holds both the necessity and foundational capacity to emerge as a national exemplar in maternal and child health equity. By advancing Healthy Beginnings toward evidence-based status, professionalizing the doula workforce, integrating perinatal mental health, addressing social determinants, and modernizing data infrastructure, the County can significantly reduce disparities and align with national best practices. These efforts are in alignment with the 2024 Maryland SHIP, the Public Health 3.0 model and a Health in all Policies approach. This framework integrates evidence and innovation, positioning the Health Department to solidify its role as Chief Health Strategist, strengthen operations and deliver measurable improvements in community health.

Tables and Figures

Table 1: Infant Health Statistics - 2023			
	Prince George's County, Overall	Prince George's County, Non-Hispanic Black	Maryland, Overall
Infant Mortality Rate (Per 1,000 Live Births)	8.1	11.8	5.7
Low Birth Weight, (% of births < 2500g)	9.4%	11.5%	8.6%
Pre-Term Birth (% of births < 37 weeks), 2023	10.9%	12.1%	10.2%

Data Source: MDH Vital Statistics Administration, 2023 Annual Report & Live Birth Data

Figure 1:

ED VISITS BY DIAGNOSIS, PRINCE GEORGE'S COUNTY, 2022

PRINCIPLE DIAGNOSIS	PRINCE GEORGE'S COUNTY ED VISITS NUMBER	PERCENT
Accidents, Injury and Poisoning	44,593	13.2%
Heart failure, Stroke, Hypertension, other circulatory diseases	31,644	9.4%
Strains, Sprains, and other musculoskeletal system and connective tissue diseases	23,395	6.9%
CLRD, Influenza, and other Respiratory Diseases (not including COVID-19)	23,300	6.9%
Neoplasms (Cancer)	21,915	6.5%
Peptic Ulcer, Irritable Bowel, Crohn, other diseases of the digestive system	21,133	6.2%
Complications of pregnancy; childbirth and postpartum	19,424	5.7%
Diabetes, Obesity, other endocrine, nutritional and metabolic diseases and immunity disorders	19,165	3.3%
Mental Illness	11,182	3.2%
COVID-19	7,856	2.3%

* ED Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Inpatient Data File 2022, Maryland Health Services Cost Review Commission

Figure 2:

HOSPITAL INPATIENT VISITS* (ADMISSIONS), PRINCE GEORGE'S COUNTY, 2022

PRINCIPAL DIAGNOSIS	PRINCE GEORGE'S COUNTY HOSPITALIZATIONS	
	NUMBER	PERCENT
Complications of pregnancy; childbirth and postpartum	10,589	16.1%
Low Birth Weight, Birth trauma, perinatal infections, and other conditions of Perinatal period (22 weeks gestation until 7 days after birth)	9,823	14.9%
Heart failure, Stroke, Hypertension, other circulatory diseases	8,564	13.0%
Tuberculosis, HIV/AIDS, Diarrhea diseases, and other Infectious and parasitic diseases	5,742	8.7%
Peptic Ulcer, Irritable Bowel, Crohn, other diseases of the digestive system	4,674	7.1%
Accidents, Injury and Poisoning	4,028	6.1%
Mental Illness	3,180	4.8%
Respiratory Diseases (not including COVID-19)	3,149	4.8%
Diabetes, Obesity, other endocrine, nutritional and metabolic diseases and immunity disorders	3,099	4.7%
Neoplasms	2,306	3.5%

* Inpatient Visits only include Maryland hospitals. Any visits made by residents to Washington, D.C. are not included, which could affect the Prince George's County rate.

Data Source: Inpatient Data File 2022, Maryland Health Services Cost Review Commission