



*The Maryland*

# Maternal Health Improvement

**2025 STRATEGIC PLAN**

**Donna M. Neale MD**  
Associate Professor, Maternal Fetal Medicine,  
University of Maryland School of Medicine  
Co-Chair, MMHI Taskforce

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


- MDMOM program
- Maternal Health Improvement Taskforce
- Maryland Department of Health

TABLE 1. U.S. AND MARYLAND MMR TRENDS <sup>5</sup>

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

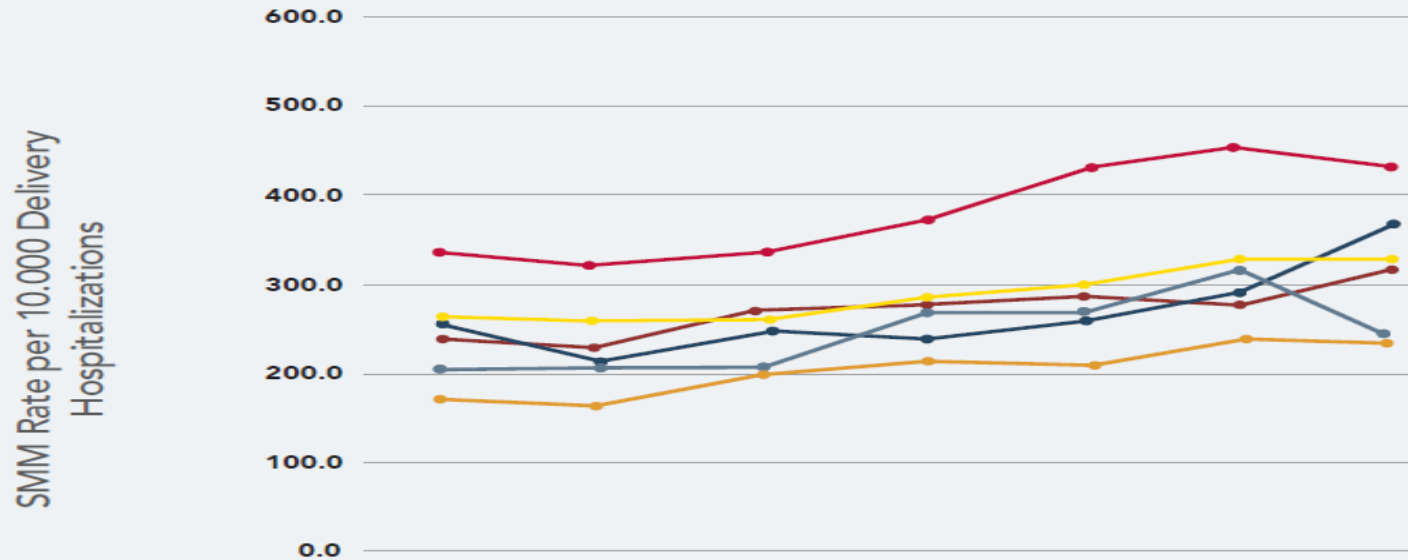
### Maryland

Year	All Races	White NH	Black NH
2010–2014	25.7	18.7	45.2
2014–2018	18.4	8.8	35.1
2019–2023	21.4	21.7	30.3



The leading causes of both pregnancy-related (i.e., death is related to the pregnant state) and non-pregnancy related (i.e., death is unrelated to the pregnant state) death were behavioral health conditions.

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



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




# Maryland Maternal Health Improvement Taskforce

<b>Donna Neale</b>	<b>University of Maryland School of Medicine</b>
Erin Anderson	Howard County Health Department
Lauren Arrington	University of Maryland St. Joseph Medical Center
Tope Bada	Howard County Health Department
Kelly Bower	Johns Hopkins University
Kristen Brooks	Building Beyond Therapy
Adriane Burgess	Maryland Patient Safety Center
Stephanie Burke	Prince George's Community College
Elizabeth Chung	Asian-American Center for Frederick
Rebecca Dineen	Baltimore City Healthy Department
Tracey DeShields	Maryland Health Care Commission - Government Affairs and Special Projects
Jackie Douge	Hood College
Danielle Haskin	Frederick County Health Department
Alyson Jacobson	Prince George's Child Resource Center
Clark Johnson	Lifefridge Sinai Hospital
Tianna Leon	Health Resources and Services Administration
Kerry Lewis	University of Maryland Capital Region Health Medical Center

Charnise Littles	Birth and Milk Co
David Mann	Maryland Department of Health
Shawn McIntosh	Maryland State Medical Society (MedChi)
Ashley Milcetic	St. Mary's County Health Department
Kristen Newmann	Prince George's County Health Department
Polsky Laurence	Calvert County Health Department
Maxine Reed-Vance	Baltimore Healthy Start
Katie Richards	Health Quality Innovators
Erika Seth Daviez	Rhia Ventures
Jeanne Sheffield	Johns Hopkins University
Jamie Swietlikowsk	Maryland Affiliate of the American College of Nurse Midwives
Denys Symonette Mitchell	Symonette Strategies and Solutions LLC.
Vacant Vacant	Maryland Hospital Association
Lisa Wright	Johns Hopkins University

## Task Force Values and Guiding Principles

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



# Taskforce Vision, and Mission

## Task Force Vision and Mission

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

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

---

# Maternal Health 2025 Strategic Plan

# Strategic Plan 2.0 Development Process

---



# HRSA Strategic Plan Requirements

## Objectives

**By September 29, 2024, 100 percent of recipients will have developed a draft strategic plan to improve maternal health**

- Including addressing identified health disparities and other gaps and incorporating activities outlined in the State Title V Needs Assessment.
- The Maternal Health Strategic Plan should reflect the most recent maternal health data available.

**By September 29, 2025, each recipient and their established Maternal Health Task Force will update and finalize the Maternal Health Strategic Plan:**

- by increasing the number of actionable recommendations based on state-level maternal health data
- Submit a final strategic plan to guide the work of the MHTF and the State MHI Program throughout the remainder of the project period.



## Taskforce Retreat

- Review progress of previous strategies from 2021 Strategic Plan
- Environmental scan to understand opportunities and threats
- Visioning session with Taskforce and other community members to understand future state in 2030
- Identify key priorities, goals and desired outcomes based on strengths and challenges and findings from Title V MCH Needs Assessment
- Stakeholder and public input

# Overarching Priorities



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

## Framework Informing the Maternal Health Strategic Plan

A Multi-Level Life Course Framework<sup>22</sup> guides the conceptualization of the strategic plan. This framework integrates two broad factors that lead to health outcomes: a person's life course and a person's exposure to their environment. Evidence for this approach comes from two models:

**Life Course Model**, which recognizes the origins of differences in health outcomes 1) through biological and behavioral mechanisms by which structurally patterned exposures during critical and sensitive periods of the life course, (e.g., the prenatal, postpartum, and early childhood periods), result in sustained shifts in health trajectories that may endure despite later intervention; and 2) through "weathering;" i.e., the hypothesis that cumulative and stress-mediated wear and tear on a cellular integrity leads to accelerated biological aging, the premature dysregulation or exhaustion of important body systems, and the early onset of chronic diseases of aging, health-induced disability, and excess mortality among marginalized groups.<sup>23</sup>

**Social-Ecological Model**, which considers the impact of and interplay between individual factors (biological and behavioral), relationships (family, friends, social networks), community factors (neighborhoods, workplaces, schools) and societal factors (cultural norms, government policies) on health and health outcomes, and suggests that these factors play critical roles in shaping health.<sup>24</sup>



## Strategic Plan Revision Timeline

- July 2024 - Planning retreat to identify priorities
- January 2025 - Initial feedback from HRSA
- May-July 2025 - Support for consultant to identify and refine priorities, goals, and objectives
- September 2025 - Submission of final plan



# Changes between 2021 and 2025 Strategic Plans

- Updated to reflect current maternal health landscape
- Incorporation of 2025 Title V Needs Assessment
- Revised & increased number of priorities
- Goals tailored to four areas:
  - Perinatal care
  - Mental & behavioral health
  - Integrated services
  - Data infrastructure

# 2025 Goals and Objectives

---



## 2025 Goals

**Goal 1:** Prevent complications of pregnancy.

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

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

**Goal 4:** Improve the ongoing collection and utilization of data on maternal health, maternal mortality, and severe maternal morbidity.




## Goal 1: Prevent complications of pregnancy

- Obj 1.a. Increase the proportion of pregnant women who receive comprehensive postpartum care by 12 weeks following delivery.
- Obj 1.b: Ensure standardized maternal urgent warning signs education is incorporated into the perinatal care continuum so that all pregnant women, their families/support networks, healthcare providers, and clinical support staff are exposed to the information.



## Goal 1: Prevent complications of pregnancy

- Obj 1.c: All hospitals will use evidence-based and comprehensive prevention strategies to lower severe maternal morbidity.
- Obj 1.d: Improve prevention, diagnosis, and treatment of hypertension across the perinatal continuum.
- Obj. 1.e: Improve prevention, diagnosis, and treatment of diabetes and reduce obesity in preconception women.



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

- Obj. 2.a: Enhance screenings (i.e., SBIRT), counseling, and medical and non-medical therapies for behavioral health conditions, including substance use disorders, depression, and anxiety.
- Obj. 2.b: Train the perinatal work force to provide mental and behavioral health support to pregnant and postpartum women and their families



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

- Obj. 3.a: Increase pregnancy and postpartum referrals and connections to services.
- Obj. 3.b: Increase enrollment in evidence-based and promising practice home visiting programs that provide comprehensive case management.



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

- Obj. 4.a: Annually evaluate the causes of maternal mortality (MMRT) and severe maternal morbidity in Maryland through analysis of surveillance data and facility-based case reviews with a focus on risk factors and underlying causes.
- Obj. 4.b: Enhance maternal health surveillance and quality initiatives through the collection of qualitative data that captures the perspectives of mothers.
- Obj. 4.c: Disseminate maternal health data using a centralized state-wide maternal health data reporting tool

# Making the Strategic Plan Actionable





## **Tactics, Partners, and Metrics**

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

## GOAL 1: PREVENT COMPLICATIONS OF PREGNANCY..

	Lead & Key Partners*	Key Metrics
<b>Objective 1.a:</b> Increase the proportion of pregnant women who receive comprehensive postpartum care by 12 weeks following delivery.		
<b>Tactic 1.a.1:</b> Convene a meeting with lead and key partners to develop a strategy and workplan that identifies key interventions to ensure all women receive two postpartum visits within 12 weeks after deliver. [Timeline: 2025-2026]	<b>Lead:</b> MHITF <b>Partners:</b> MDPQC, FQHCs, local health departments and home visiting programs, birthing hospitals, neonatal and perinatal providers, MIECHV, MDH, community-based organizations	<b>Metric:</b> Percent of women who attend a postpartum checkup within 12 weeks after giving birth. [Source: PRAMS]

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

**Tactic 1.b.1:** Distribute urgent maternal warning signs educational materials to hospitals, home visiting programs, and other programs serving pregnant and postpartum families (e.g., WIC).  
[Timeline: 2025-2028]


**Tactic 1.b.2:** Conduct training of emergency department staff to identify urgent maternal warning signs.  
[Timeline: 2025-2028]

**Lead 1.b.1:** MDMOM

**Lead 1.b.2:** MPSC

**Partners:** Local health departments and home visiting programs, WIC, MDPOC, FQHCs, birthing hospitals, MIECHV, MDH, community-based organizations, perinatal, pediatric, primary, and emergency care providers

**Metrics:** Number and source of request for materials. Number of posters, handouts, and magnets distributed.  
[Source: MDMOM]



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

**Tactic 1.c.1:** Hospital implementation of AIM patient safety bundles including completion of the OB hemorrhage bundle with transition to sustainability planning by June 2026.

**Tactic 1.c.2:** Make an informed selection of the next statewide perinatal safety initiative using maternal health data and stakeholder feedback by July 2026.

**Lead:** MDPQC

**Partners:** MDH, MHITF, birthing hospitals

**Metric:** All Maryland hospitals actively participate in perinatal safety and quality initiatives. [Source: MDPQC]

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

**Tactic 1.d.1:** Distribute free blood pressure cuffs to all patients with hypertensive disorders of pregnancy (HDP) during prenatal care or before postpartum discharge. [Timeline: 2025-2030]

**Tactic 1.d.2:** Facilitate co-learning among birthing hospitals with standardized postpartum HDP care plans, including early postpartum follow-up care. [Timeline: 2025-2026]

**Tactic 1.d.3:** Monitor and report data annually on timely diagnosis and treatment of hypertension. [Timeline: 2025-2030]

**Lead 1.d.1:** MDMOM & Maryland Medicaid Managed Care Organizations (MCOs)

**Lead 1.d.2:** MDPQC


**Lead 1.d.3:** MDPQC

**Partners:** MHITF, birthing hospitals, perinatal care providers, MPSC, MDPQC, BHB, Maryland Medicaid, Maryland MFPP, MIECHV, MDH, WIC, private health insurers, community-based organizations

**Metrics:** Number of blood pressure cuffs distributed by MDMOM annually. [Source: MDMOM]

Number of individuals scheduled for postpartum follow up within 7 days. [Source: MDPQC]

Percent of patients with severe hypertension receiving treatment within one hour. [Source: MDPQC]



---

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

---

**Tactic 1.e.1:** Establish partnerships with stakeholders to increase awareness and education.  
[Timeline: 2025-2026]

**Tactic 1.e.2:** Create a maternal health roadmap with a focus on preconception health, including diabetes and obesity.  
[Timeline: 2027]

**Lead:** MHITF  
**Partners:** Local health departments programs, school-based health centers, WIC, MFPP, YMCA, Maryland Recreation Parks and Planning, community-based organizations, perinatal, primary, OB/GYN, and pediatric providers

**Metric:** Roadmap is created.  
[Source: MHITF]

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

	Lead & Key Partners*	Key Metrics
<b>Objective 2.a:</b> Enhance screenings (i.e., SBIRT), counseling, and medical and non-medical therapies to be utilized for behavioral health conditions, including substance use disorders, depression, and anxiety.		
<p><b>Tactic 2.a.1:</b> Host a consultation service hotline for providers to ask questions and access resources and referral information for supporting pregnant patients with a substance use disorder. [Timeline: 2025-2028]</p> <p><b>Tactic 2.a.2:</b> Conduct provider training on prescribing and managing patients on medications for the treatment of opioid use disorders and Extension for Community Healthcare Outcomes (ECHO) sessions on related topics. [Timeline: 2025-2028]</p> <p><b>Tactic 2.a.3:</b> Provide case management services to pregnant women on Medicaid with opioid use disorder. [Timeline: 2025-2028]</p>	<p><b>Lead 2.a.1&amp;2:</b> MACS for MOMs</p> <p><b>Lead 2.a.3:</b> Maryland Medicaid</p> <p><b>Partners:</b> MIECHV, MFPP, Medicaid MCOs, perinatal care providers, substance use disorder treatment clinics</p>	<p><b>Metric:</b> Number of MACs for MOMs program participants and services provided.</p> <p>Percent of training participants who report it informed their clinical practice [Source: MDH]</p>

**Objective 2.b:** Train the perinatal work force to be equipped to provide mental and behavioral health support to pregnant and postpartum families.

**Tactic 2.b.1:** Provide training and disseminate the Mothers and Babies depression prevention program delivered by maternal, infant, and early childhood home visitors. [Timeline: 2025-2026]

**Tactic 2.b.2:** Conduct and disseminate findings from a needs assessment that identifies barriers to accessing perinatal mood and anxiety disorder treatment. [Timeline: 2026]

**Tactic 2.b.3:** Implement a statewide Perinatal Mental Health Training Hub to support perinatal mental and behavioral health workforce development and increase linkages to care for pregnant and postpartum women. [Timeline: 2027-2028]

**Tactic 2.b.4:** Expand utilization of existing resources and materials already developed (e.g., 988 and the Maryland Maternal Health Resource Map). [Timeline: 2025-2030]

**Lead 2.b.1:** MDMOM

**Lead 2.b.2:** MDH, MHITF

**Lead 2.b.3:** MDH

**Lead 2.b.4:** MHITF

**Partners:** MIECHV, MACS for MOMs, Maryland Medicaid, local health departments and home visiting programs, perinatal providers, community-based organizations

**Metrics:** Number of home visiting programs and staff trained to deliver the Mothers and Babies intervention. [Source: MDMOM]

Needs assessment findings presented to the MHITF. [Source: MDH]

Number of Training Hub participants who completed all requirements to achieve the PMH-C credential. [Source: MDH]

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

	Lead & Key Partners*	Key Metrics
<p><b>Objective 3.a:</b> Increase pregnancy and postpartum referrals and connections to services.</p>		
<p><b>Tactic 3.a.1:</b> Expand use of the Maryland Prenatal Risk Assessment (MPRA) and the Postpartum Infant and Maternal Referral Form (PIMR), and ensure connections are made based on those referrals. [Timeline: 2025-2028]</p> <p><b>Tactic 3.a.2:</b> Distribute the Maternal Health Resource Map to pregnant and postpartum families and care providers. [Timeline: 2025-2028]</p> <p><b>Tactic 3.a.3:</b> Strengthen referral pathways from perinatal providers to community-based lactation supports. [Timeline: 2025-2028]</p>	<p><b>Lead 3.a.1&amp;3:</b> MDH</p> <p><b>Lead 3.a.2:</b> MDMOM</p> <p><b>Partners:</b> MIECHV, MFPP, FQHCs. BHS, Thrive by Three, Centering Pregnancy®, WIC, BHB, Maryland Medicaid, MDQPC, MHITF, birthing hospitals, local health departments and home visiting programs, perinatal, primary care, and pediatric providers</p>	<p><b>Metrics:</b> Number of pregnant or postpartum individuals receiving a standardized risk assessment (MPRA and/or PIMR), total and by insurance type. And the number referred for breastfeeding/lactation services. [Source: MDH IMHS]</p> <p>Number of unique views of the Maternal Health Resource Map site &amp; Maternal Health Report Card [Source: MDMOM &amp; MDH]</p>

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

**Tactic 3.b.1:** Survey home visiting programs for services offered that are evidenced based. [Timeline: 2025-2030]

**Tactic 3. b.2:** Connect home visiting programs to collaborate and share resources and establish benchmarks. [Timeline: 2025-2030]

**Tactic 3.b.3:** Expand the MIECHV program to 24 jurisdictions (pending funding availability and interest). [Timeline: 2025-2030]

**Tactic 3.b.4:** Promote the use of community health workers and home-visiting staff to screen patients for comprehensive services connecting this screening to reliable and effective local interventions. [Timeline: 2025-2030]

**Lead:** MIECHV

**Partners:** Local health departments and home visiting programs, community-based organizations

**Metric:** Number of new and continuing enrollees by category (pregnant caregivers, other adult caregivers, target children), overall and by race/ethnicity. [Source: MDH]

Percent of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery. [Source: MDH]

Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally). [Source: MDH]

## GOAL 4: IMPROVE THE ONGOING COLLECTION AND UTILIZATION OF DATA ON MATERNAL HEALTH, MATERNAL MORTALITY, AND SEVERE MATERNAL MORBIDITY.

	Lead & Key Partners*	Key Metrics
<b>Objective 4.a:</b> Annually evaluate the causes of maternal mortality (MMRT) and severe maternal morbidity in Maryland through analysis of surveillance data and facility-based case reviews with a focus on underlying causes.		
<p>Tactic 4.a.1: Assimilate data from annual report card of birthing hospitals, the Maternal Mortality Review Program, and the SMM Surveillance and Review Program [Timeline: 2026].</p> <p>Tactic 4.a.2: Analyze data and present the information to the Task Force. [Timeline: 2027]</p> <p>Tactic 4.a.3: Conduct reviews of pregnancy-associated deaths through the Maternal Mortality Review Program and present annual reports. [Timeline: 2025-2030]</p>	<p><b>Lead:</b> MDH</p> <p><b>Partners:</b> MDMOM, birthing hospitals, MDPQC, MHITF</p>	<p><b>Metrics:</b> All birthing hospitals participate in SMM Surveillance Review Program by reporting SMM case data. [Source: MDMOM]</p> <p>Maternal Health Hospital Report Card presents information on key indicators by hospitals and is updated annually. [Source: MDH]</p>

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

**Tactic 4.b.1:** Conduct interviews with patients and/or close contacts through the SMM Surveillance and Review Program and the Maternal Mortality Review Program. [Timeline: 2025-2028]

Tactic 4.b.2: Enhance programmatic reporting among programs that serve Maryland families to better capture qualitative stories and perspectives. [Timeline: 2025-2030]

Tactic 4.b.3: Elevate significant findings to the provider level to improve service delivery. [Timeline: 2025-2030]

Lead 4.b.1: MDMOM & MDH

Lead 4.b.2&3: MDH

Partners: MIECHV, MFPP, MHITF, Baltimore Healthy Start, MDPQC, local health departments, birthing hospitals, community-based organizations

Lead 4.b.1: MDMOM & MDH

Lead 4.b.2&3: MDH

Partners: MIECHV, MFPP, MHITF, Baltimore Healthy Start, MDPQC, local health departments, birthing hospitals, community-based organizations

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

Tactic 4.c.1: Launch the Maternal Health Hospital Report Card in July 2025, to be updated at least once every three years. [Timeline: 2025-2030]

Tactic 4.c.2: Publish an annual report on the findings from the SMM Surveillance and Review Program. [Timeline: 2025-2028]

Lead 4.c.1: MDH

Lead 4.c.2: MDMOM

Partners: MHITF, birthing hospitals

Metrics: Centralized state-wide maternal health data reporting tool created and made publicly available. [Source: MDH]

Report on SMM Surveillance and Review Program findings published annually. [Source: MDMOM]

\*Baltimore Healthy Start (BHS); B'more for Healthy Babies (BHB); Federally Qualified Health Centers (FQHCs); Maryland Addiction Consultative Services (MACS for MOMs); Maryland Department of Health (MDH); Maryland Family Planning Program (MFPP); Maternal Infant and Early Childhood Home Visiting (MIECHV); Maryland Maternal Health Improvement Task Force (MHITF); Maryland Maternal Health Innovation Program (MDMOM); Maryland Patient Safety Center (MPSC); Maryland Perinatal Neonatal Collaborative (MDPQC); Women's, Infants & Children (WIC) program

# Task Force Engagement and Specific Deliverables

---



- Task Force is **responsible** lead in **4 tactics**
  - **Consulted** partner in **6 tactics**

# Task Force-led Tactics

Goal 1: Prevent complications of pregnancy

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

Tactic	Metric
Tactic 1.a.1: Convene a meeting with lead and key partners to develop a strategy and workplan that identifies key interventions to ensure all women receive two postpartum visits within 12 weeks after delivery [Timeline: 2025-2026]	Metric: Percent of women who attend a postpartum checkup within 12 weeks after giving birth. [Source: PRAMS]

# Task Force-led Tactics

Goal 1: Prevent complications of pregnancy

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

Tactic	Metric
Tactic 1.e.1: Establish partnerships with stakeholders to increase awareness and education. [Timeline: 2025-2026]	Metric: Roadmap is created. [Source: MHITF]
Tactic 1.e.2: Create a maternal health roadmap with a focus on preconception health, including diabetes and obesity. [Timeline: 2027]	

# Task Force-led Tactics

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

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

Tactic	Metric
Tactic 2.b.2: Conduct and disseminate findings from a needs assessment that identifies barriers to accessing perinatal mood and anxiety disorder treatment. [Timeline: 2026]	Metrics: Needs assessment findings presented to the MHITF. [Source: MDH]
Tactic 2.b.4: Expand utilization of existing resources and materials already developed (e.g., 988 and the Maryland Maternal Health Resource Map). [Timeline: 2025-2030]	

---

# Ongoing Taskforce Efforts



## **3 Working Groups for Taskforce Led Tactics**

Preconceptual, Mental Health and Post partum Care



## Strategic Plan Timeline

- July 2026 – 1<sup>st</sup> draft of work plans
- October 2026 – 2<sup>nd</sup> draft of work plans
- January 2027 – Final plan
- February 2027 – December 2029 – Implementation
- January – July 2030 – Analysis of plan
- August – December 2030 – Preparation of Report to HRSA



# Community Partnerships



## Task Force-Consulted Tactics

Tactic 1.c.1	Tactic 3.a.2	Tactic 4.b.2
Tactic 1.c.2	Tactic 3.a.3	Tactic 4.b.3
Tactic 1.d.1	Tactic 4.a.1	Tactic 4.c.1
Tactic 1.d.2	Tactic 4.a.2	Tactic 4.c.2
Tactic 1.d.3	Tactic 4.a.3	Tactic 4.c.3
Tactic 3.a.1	Tactic 4.b.1	



## **Taskforce Discussion**

How would the Task Force like to be consulted on activities where it is not the lead?

## **Sustainability**

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



# Maternal Health 2025 Strategic Plan

- Available on [MDMOM website](#)
- Direct report link:  
[https://mdmom.org/sites/default/files/documents/taskforce/Maryland\\_Maternal\\_Health\\_Improvement\\_Strategic\\_Plan\\_2025\\_vF.pdf](https://mdmom.org/sites/default/files/documents/taskforce/Maryland_Maternal_Health_Improvement_Strategic_Plan_2025_vF.pdf)





**Thank you**