MNPQC

PERINATAL EDUCATION ECHO SERIES

MAY 21, 2026 | SESSION SNAPSHOT

Minnesota Maternal Mortality: Findings from the 5-Year Report 2017-2021

SESSION SUMMARY

This session provided listeners with an overview of Maternal Mortality Review Committees (MMRCs), which are considered to be the gold standard for maternal mortality surveillance. The session also summarized key findings for the Minnesota MMRC five-year report (2017-2021), and focused on the top three causes of pregnancy-related deaths with future recommendations to reduce maternal deaths in Minnesota.

HONORING THE LIVES LOST

This session and session snapshot honor the lives of 162 individuals who died while pregnant or within one year of giving birth in Minnesota during 2017 - 2021 and for the families they left behind.

OVERALL KEY TAKEAWAYS

Overall Findings from the 5-Year Report

Of the 162 deaths, **95%** of pregnancy-related deaths were preventable.

More than 70% of both pregnancy-related deaths and pregnancy-associated, but not related deaths, **occurred during the postpartum period.**

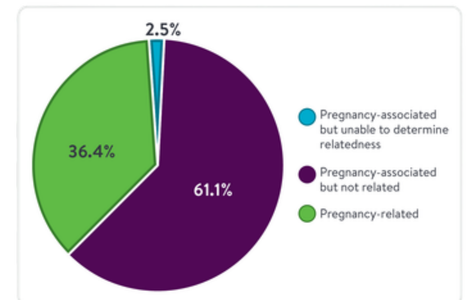
Outcomes by Place

In Northwest and Northeast Minnesota, the disproportion of births vs deaths is alarming, due to limited availability of transportation to care, access to birth-friendly medical centers or clinics, and limited supportive services. (See Figure 3 on pg. 19 on the MMRC 2017-2021 report)

Outcomes by Race: MN Pregnancy Related Mortality Ratio (PRMR)

In Minnesota, the PRMR is 217.7% per 100,000 births for American Indian birthing people and 40.3% per 100,000 births for Non-Hispanic Black birthing people, indicating significant disparities in outcomes. See Table 1 (Right).

MN Maternal Deaths Years 2017-2021



Source: Minnesota MMRC 2017 - 2021 Report

Table 1 - PRMR by Race: MN 2017-2021

Race/ethnicity	Number of pregnancy-related deaths	Pregnancy-related mortality ratio
Non-Hispanic White	22	9.9
Non-Hispanic Black	16	40.3
American Indian	10	217.7
Hispanic	6	NA
Asian	5	NA

***Disclaimer**: Rates/percentages based on <20 deaths are statistically unstable; interpret with caution. Number of live births used in the denominators to calculate rates: Non-Hispanic White=222,737; Non-Hispanic Black=39,681; American Indian=4,594*

Source: Minnesota MMRC 2017 - 2021 Report

LESSONS FROM TOP 3 PREGNANCY-RELATED DEATHS

#1 - Mental Health Conditions

Of the 162 deaths, **28.8% were due to mental health conditions**, including substance use disorders (n = 17).

Recommendations:

- Implement universal screenings
- Include mental health and SUD as part of perinatal care
- Take ownership in sharing resources with individuals
- Prioritize trauma-informed care (TIC)

#2 - Violent Death or Injury

Of the 162 deaths, **13.6% were due to violent death or injury** (n = 8). Among these violent deaths, **35.7% were suicides and 64.3% were homicides.**

Recommendations:

- Partner with law enforcement to support families, not criminalize
- Partner with community organizations
- Connect individuals to trauma specialists & other prevention strategies

#3 - Infections

Of the 162 deaths, **11.9% were due to infections** (n = 7), including COVID-19 (n = 5) and sepsis (n = 2).

Of five COVID deaths, three were pregnancy-related, and two were pregnancy-associated but not related. Four occurred postpartum and one during pregnancy.

Recommendations:

- Increase trust with culturally-centered outreach
- Recommend vaccines
- Educate on self-advocacy

Updated as of May 2026

WHAT ARE MMRCs & WHY THEY MATTER

MMRCs are comprehensive reviews of deaths that occur during pregnancy or within one year postpartum. These committees go *beyond* national data systems because they use multiple data sources and work alongside a multidisciplinary team of abstractors, who investigate pregnancy-related deaths to help tell the full story. This broader picture includes not only why a death is considered pregnancy-related, but also the circumstances that occurred leading up to a death during pregnancy or the postpartum period.

Key Terminology:

- **Pregnancy-associated death:** A death that occurs during pregnancy or within one year after pregnancy, regardless of the cause.
- **Pregnancy-related death:** A death caused by pregnancy complications, conditions made worse by pregnancy, or events linked to pregnancy or childbirth.
- **Pregnancy-associated, but not-related death**: A death that occurs during pregnancy or within one year after birth from a cause unrelated to pregnancy.

PRESENTER CONTACT

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RESOURCES SHARED

- **Minnesota Maternal Mortality Review Committee Report** (2017-2021)
- **Task Force on Pregnancy Health and Substance Use Disorders:** Established to recommend protocols for when healthcare professionals should administer a toxicology test and requirements for reporting prenatal exposure to a controlled substance.
- **Perinatal Health Data Dashboard:** The dashboard was created to focus on infant or maternal outcomes or care delivery. For each topic, there is an overview page with key data highlighted, as well as an interactive page for users to look at additional demographic and program use factors.
- **Postpartum Support International | Perinatal Mental Health Training | Duluth, MN | October 7-8, 2026**
- **Perinatal Resource Map:** Developed by the MNPQC to provide a wide range of perinatal resources tailored for professionals and birthing families across Minnesota. Are we missing something? **Submit A Resource**

ADDITIONAL DETAILS

If you have **questions about this session snapshot or would like to request access to the session slides**, please contact the QI Team: QI@minnesotaperinatal.org.

Learn more about this ECHO Series. Visit our ECHO webpage.

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