
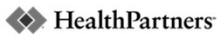


2026 AWHONN-MN Advocacy and Legislative Updates

Jennifer Almanza, DNP, APRN, CNM
4-16-2026 AWHONN-MN State Conference

In honor of the 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.

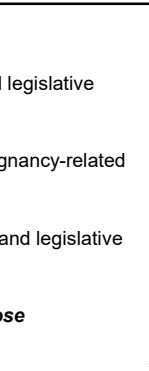



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Objectives



- ❖ Create awareness of AWHONN-MN's advocacy and legislative priorities
- ❖ Examine key findings and recommendations on pregnancy-related deaths in MN
- ❖ Identify ways to be involved in AWHONN advocacy and legislative work

I have no financial interests to disclose



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Advocacy & Policy Work




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Call for Safe, Fear-Free Access to Healthcare for All Families in Minnesota and for the Protection of Healthcare Workers from Violence.

As organizations committed to the health and wellbeing of families, ACNM-MN and AWHONN-MN affirm our unwavering, equitable, and compassionate care to every individual.

Across Minnesota, clinicians are witnessing a growing fear of immigration enforcement agents in and around healthcare access to essential care. Families are delaying urgent surveillance, detention, or separation. These fears have unplanned home births despite high-risk conditions, pt families to remain at home - even when lawfully present avoidable medical complications.





Judges decry treatment of nursing and pregnant detainees in ICE custody

The agency has declined to say whether a Biden-era policy largely barring detention for pregnant and nursing mothers remains in force.

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Release of 5 Year MMRC Report – January 2026

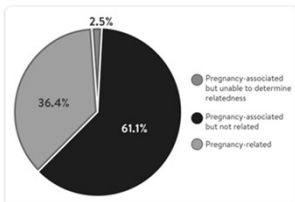
Minnesota Maternal Mortality Report

2017-2021




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Key Statistics: MN Maternal Deaths Years 2017-2021 (N=162)

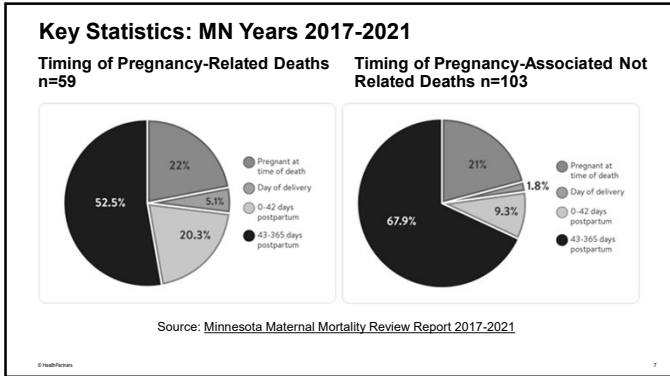


95% of pregnancy-related deaths were preventable (n=56 of n=59).

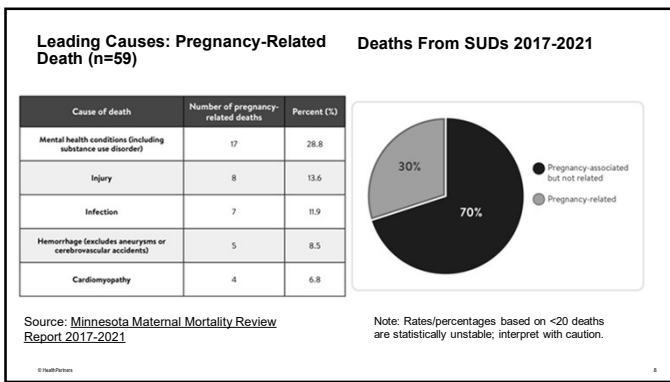
"A death is preventable if there was at least some chance it could have been avoided with reasonable changes to patient, family, provider, facility, and/or community factors"

Source: [Minnesota Maternal Mortality Review Report 2017-2021](#)

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Committee Recommendations for SUD

Universal screening (not testing) and follow-up referrals

Examples:
-EPDS and 5P's

Embed mental health and SUD Tx into perinatal care:

- Family based care
- Close follow-up

Facilitate connections to community health resources:

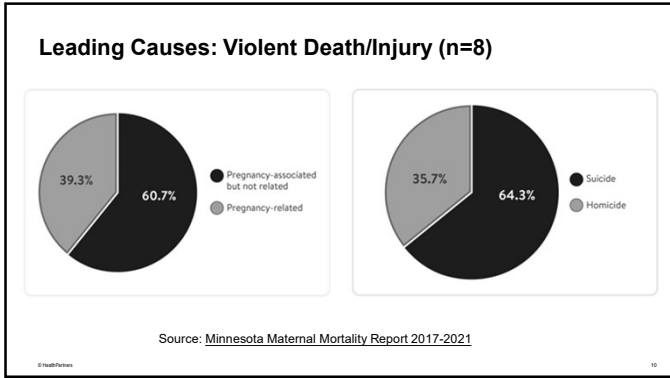
- MNPQC map
- Establish relationships

Expand the Perinatal Health Care Workforce (next slide)

Address poverty; consider models that provide supplemental income for basic needs

Implement recommendations from MDH Task Force on Pregnancy Health and SUD

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Committee Recommendations: Violent Death

Enhanced tracking of violent death in pregnancy/postpartum target Gaps	Pathways to support families with basic needs in the postpartum year	Law enforcement to develop pathways to refer individuals in crisis to supportive services – not criminalize	Partner with community organizations Examples -Futures Without Violence -Violence Free MN
Implement suicide prevention strategies Early intervention with triggered screenings	Implement recommendations from MDH Task Force on Pregnancy Health and SUD	Access to mental health and SUD care Early visits for postpartum care (within first two weeks)	

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Covid-19 Recommendations n=5		Sepsis Recommendations n=2	
Address SDoH	Clear Policies/Guidelines	Use OB Sepsis Guidelines	Work with ED & IP
Engage Community Health Services	Recommend Vaccines	Review House-wide Policies to Ensure OB inclusion	Use Pregnancy Adjusted Criteria
Mobile Clinics and Culturally-Centered Outreach	Early and Ongoing Assessment for HR People	Implement Sepsis Roadmaps	Educate Patients on Self Advocacy

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Twin Cities Metro - All Services

Source: MNPQC Perinatal Resource Map

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Northwest and Northeast All Services

Source: MNPQC Perinatal Resource Map

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“Maternal mortality is not a health problem. Maternal mortality is a social problem with health consequences.”

-Dr. Marsden Wagner

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“Action is the antidote to despair.”
Joan Baez

Come join me!

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Resources & References

[Minnesota Maternal Mortality Report 2017-2019](#)
[Task Force on Pregnancy Health and Substance Use Disorders](#)
[MNPQC Perinatal Resources Map](#)
[Pregnancy-Related Deaths: CDC Data from Maternal Mortality Review Committees 2017-2021](#)
[ACOG Policy Priorities: Eliminating Preventable Maternal Mortality and Morbidity](#)
[Pregnancy-Related Deaths Among American Indian or Alaska Native Women: Data from Maternal Mortality Review Committees](#)
[Roadmap for Native Maternal Health Solutions](#) – link to 5 individual reports.
[FastAction link to investigate human rights abuses in ICE detention centers](#)
[Politico article on pregnant ICE detainees](#)
Smid, M. C., Vaughn, P., Nowicki, C. C., Goodman, D. A., Zaharatos, J., & Campbell, K. A. (2024). Consensus pregnancy-related criteria for suicide and unintentional overdoses using a Delphi process. *Archives of women's mental health*, 27(1), 109–125. <https://doi.org/10.1007/s00737-023-01375-4>



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Excellence Partnership Integrity Compassion



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