We've offered the Raleigh community space-saving solutions for the past 10 years. We recommend Northwind Traders to anyone who will listen to us. They helped us reclaim over 700 square feet of our house! — Annie D. Balitmore

“There is no pain so great as the memories of joy in present grief”

- Aeschylus

Utah Department of Health
Division of Family Health and Preparedness
Maternal and Infant Health Program

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PMR Program

Perinatal Mortality Review (PMR) is a process aimed at identifying and examining the factors that contribute to perinatal (infant and maternal) deaths through the systematic evaluation of individual cases.

The fundamental goal of the PMR program is to improve infant and maternal outcomes. This involves a wide range of helpful strategies, from clinical remedies to changes in the health/social services delivery system and public policies throughout Utah.

The objectives of the PMR program are:

- Provide pertinent data on maternal and infant health issues
- Provide a way for community experts to make recommendations that are aimed at improving delivery of health care services for women and children
- Provide a framework for the essential collaboration between public and private health care providers
- Develop a review process that is implemented in some meaningful form on an ongoing basis

Program Details

The PMR program is a public health approach to improve infant and maternal outcomes in Utah. The Utah Department of Health is responsible for the oversight and coordination of the program. This allows for legal protections, program neutrality, and the fostering of beneficial partnerships.

Case reviews have been conducted by a committee of professionals since 1995. Committee members provide analytical skills, community perspective, and clinical expertise. Utah’s program is based on the National Fetal and Infant Mortality Review (NFIMR) Program.

Review Process

Perinatal deaths are analyzed in relationship to the following factors:

- Demographics
- Education
- Environmental risk factors
- Lifestyle
- Health care interventions
- Public health policies
- Access to services
- Economics
- Health care compliance

Abstraction Process

Information is obtained through medical records abstraction to assist in identifying gaps in the health care delivery system. Information may be obtained from birth/death certificates, hospital charts, health care provider records, emergency room records, autopsy reports, and police records*.

*Under the Health Data Authority Act, UT code 26-25-1, the program ensures confidentiality of all information reviewed.

Benefits

Infant and maternal deaths are unexpected events that can serve to identify episodes of health care system failures and the reasons behind such failures.

The reasons are then examined to determine if they represent a consistent or alterable policy, or if they represent an unusual occurrence not amenable to corrections.

These reviews result in the discovery of factors that may negatively impact perinatal outcomes. Identifying these factors leads to public health recommendations for changes that could improve the outcome of future cases.

Recommendations from committee deliberations are presented to appropriate organizations and individuals as a quality improvement mechanism designed to decrease the number of poor perinatal outcomes.

Committee Members

- Perinatologist
- Neonatologist
- Pediatrician
- Obstetrician
- Family practice physician
- Certified nurse-midwife
- Neonatal nurse practitioner
- Public health professional
- Social worker
- Home birth midwife
- Ad hoc members on case-by-case basis (i.e. geneticist, neurologist and cardiologist)