CASE REVIEW TEAM MEMBERS

The role of a Fetal & Infant Death Review (FIMR) Case Review Team (CRT) is to act as the "information processor" for the FIMR program. Information collected in the family interviews and the medical abstractions is summarized by the Healthy Start Coalitions' FIMR program staff in a Case Summary Report, which is sent out to the CRT members prior to the meeting in which the case will be reviewed. The CRT team will analyze the Case Summary Report and create recommendations to improve our community's service delivery system and resources.

WHAT ISSUES WILL THE GROUP BE EXPLORING?

- *What economic, health services systems, community resources or personal factors helped this family?*
- *Did the family receive the services and resources they needed?*
- *What are the local service delivery issues that the case highlights?*
- *Are there gaps in the system or community resources?*
- *Is it possible to design and implement more responsive community resources or service delivery systems? What should they look like?*

FETAL & INFANT MORTALITY REVIEWS CAN ACCOMPLISH:

- ✓ **Recognition of Sentinel Events**. Sentinel events are clear warning signals that the quality of services need to be improved and include those cases that in themselves exemplify a particular problem or situation contributing to infant or fetal mortality
- ✓ **Trends**. Over the course of time, several cases will illustrate similar problems or situations
- ✓ **Incidental Findings**. Findings not directly related to the fetal or infant death are often discovered as part of the FIMR process, such as gaps in care or services such as bereavement information and services

WHAT FIMR PROGRAMS *DO NOT* ACCOMPLISH:

- They are not conducting case reviews to determine *individual* causes of death or to categorize the deaths
- FIMR's do not attempt to assess individual preventability; that is often speculative or key information is lacking or inconsistent
- They are not fault-finding or assigning blame for the death. Blame cannot be determined with the subsets of information that FIMR abstracts, nor should it be attempted -- *comprehensive local and state professional peer review and institutional quality assurance programs already exist to respond to this issue*
- FIMR's do not conduct research on the causes of infant death—rather, they are tracking the social, economic, and systems factors associated with the death for the purpose of improving the care and resources available to families in their specific community

What CRT Members are Committing to:

- A one-time virtual, self-paced FIMR training
- One, 2-3 hour meeting once per month (*no meetings* in June & December)
- Time to review Case Summary Reports prior to monthly meeting (3-4 cases)

Next Steps:

- Introductory meeting being planned for early ***January 2023***
- First Case Review Team (CRT) meeting to take place at the end of ***January 2023***
- First Community Action Group (CAG) meeting to take place in ***March 2023***
- ***Have questions?*** Contact Shelly Vickers at svickers@wellflorida.org or 352-313-6500 x8032
- ***Ready to become part of the team?*** Please use QR code below for next steps or go to https://www.surveymonkey.com/r/2022FIMRCRT