Role of Community Review Team Members

In general the role of a CRT member is that of an "information processor" for the infant death review program. The information collected in interviews and medical abstractions is reviewed and analyzed in such a way as to summarize findings and create recommendations to improve the entire community's service delivery system and resources.

After reading the FIMR summary of a particular case, the team should discuss the following:

- 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?

FIMR's can accomplish three things:

1. Recognition of Sentinel Events. Sentinel events are defined as clear warnings 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 mortality.
2. Trends. Over the course of time, several cases will illustrate similar problems or situations.
3. Incidental Findings. Incidental findings are often discovered as part of the FIMR process, gaps in care or services that may not be directly related to the cause of death. (such as lack of bereavement services)

What FIMR programs ***do not*** accomplish:

1. They are not conducting case reviews to determine *individual* causes of death or to categorize the deaths.
2. FIMR's do not attempt to assess *individual* preventability; that is often speculative or key information is lacking or inconsistent.
3. 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 QA programs already exist to respond to this issue.

4. 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.