JOAN BALLWEG
STATE SENATOR · 14TH SENATE DISTRICT

Assembly Bills 184, 185, 186, 187, 188, and 189
Recommendations by the
2022 Study Committee on Uniform Death Reporting Standards

Testimony of Senator Joan Ballweg
Assembly Committee on Health
August 10, 2023

Good morning, Chair Moses, and members of the committee. Thank you for hearing this package of bills, which were recommended unanimously after months of study and discussion by the 2022 Study Committee on Uniform Death Reporting Standards.

I had the pleasure to serve as chairperson of the committee, which was comprised of two senators, two representatives, and seven public members. The public members ranged in expertise, including two medical examiners, a public health nurse, a funeral director, and various mental health and research advocates.

The idea for a Study Committee on Uniform Death Reporting Standards came after I served as Chair of the Speaker's Task Force on Suicide Prevention in the 2019 legislative session.

The committee was tasked with analyzing ways to improve our data on deaths, with the idea that better data will better inform death prevention efforts, particularly in the context of suicide. To that end, the committee heard testimony about, and had in-depth discussions on, the need for more uniform information included in death records. Death record data relies heavily on the work of various actors, including funeral directors, physicians, and county medical examiners/coroners.

In addition, the committee heard testimony about efforts to gather death-related information using other tools beyond death records. For example, standardized suicide investigation forms and fatality review teams are ways that some public health and other professionals are gathering comprehensive data on certain kinds of deaths. The goal of these tools is to assist stakeholders in identifying risk factors that can better inform preventative efforts.

In the interest of time, I will not describe in detail each of the six bills being heard today, but rather explain the three specific themes under which the bills may be categorized, which were the product of robust discussion and consensus.

Capitol Office: P.O. Box 7882 · Madison, WI 53707-7882 · (608) 266-0751 · Toll-Free: (800) 991-5541
Fax: (608) 282-3554 · Sen.Ballweg@legis.wisconsin.gov

First, the committee devoted significant discussion to the value of fatality review teams. Many counties currently have review teams of various types, but no state law governs their use. These teams discuss individual deaths, in a confidential setting, with the goal of identifying risk factors and circumstances that surround the death, so as to inform future prevention strategies. Recognizing the value of these teams, Assembly Bill 188 codifies the existence of these teams in order to legitimize their practice, specify the confidential nature of their meetings, and clarify a team's ability to access certain records.
In addition, three of the bills address the content of a death record and the process for creating a death record by:

- Allowing inclusion of up to two additional occupation entries to the death record to provide better data about decedents with multiple occupations (Assembly Bill 184).
- Requiring individuals to certify the cause and manner of death using an existing DHS electronic system to ensure timeliness, accuracy, and uniformity (Assembly Bill 185).
- Ensuring that medical examiners and coroners receive notice of certain deaths in order to determine whether to take jurisdiction, so as to assist in timely submission of certain death record data (Assembly Bill 189).

Finally, two bills seek to create more uniformity among medical certifications of cause and manner of death by:

- Requiring DHS to establish and encourage best practices for coroners and medical examiners when completing medical certifications and death investigations (Assembly Bill 187).
- Requiring DHS to promote and encourage appropriate training for any person who is authorized to complete and sign a medical certification (Assembly Bill 186).

Again, I appreciate the opportunities both to have chaired this study committee and to testify before you on these six bills. Legislative Council attorneys Amber Otis and Kelly McGraw are with me today to assist in answering any questions.

Capitol Office: P.O. Box 7882 · Madison, WI 53707-7882 · (608) 266-0751 · Toll-Free: (800) 991-5541
Fax: (608) 282-3554 · Sen.Ballweg@legis.wisconsin.gov

STATE SENATOR JESSE JAMES 23RD DISTRICT

August 10th, 2023

Members of the Assembly Committee on Health, Aging and Long-Term Care

Testimony on 2023 Assembly Bills 184, 185, 186, 187, 188, & 189

Relating to bills suggested by the Legislative Council Study Committee on Uniform Death Reporting

Thank you, Chairman Moses and other members of the committee, for hearing these bills today. The proposals before you came from the Legislative Council Study Committee on Uniform Death Reporting Standards, for which I was honored to serve as the Vice-Chair. Our task was to review the current protocols for investigating causes of death, reporting deaths, and the uniformity of those practices across the state. As tragic as death can be, it can also be incredibly informative when it comes to identifying trends and potential short comings in our system and society. Improving the reporting requirements and processes for all types of death, but especially unexpected ones, can help strengthen the validity of this data.

Throughout the study committee meetings, we got to hear from multiple people across different professions that are involved in not only certifying a death, but reporting the necessary information to the Wisconsin Vital Records Office. Their presentations and testimonies shined a light on areas of the process that need improvement. The bills before you can be broken down into three major categories for the death reporting process: creating a death record, certification uniformity, and additional data sources regarding death.

Assembly Bill 184, 185, and 189 pertain to the creation of the death record. If one of the goals of this committee was to help identify trends and strengthen statistics, AB 184 helps with painting a better picture of the life of the recently deceased. It allows for adding more than one occupation for the individual, which can provide insight to different environmental factors that could have influenced health and wellbeing. AB 185 would aim to alleviate potential human error when filling out the death record by requiring the individuals signing the medical certification to use the electronic vital records system. Electronically entering this data would minimize the misinterpretations of what was written and then faxed, helping ensure the information used for the death record is accurate. Lastly, AB 189 puts a 24 hour timeline on when a hospital or similar institution needs to contact a medical examiner or coroner about a death in the facility to see if investigation is needed.

AB 186 and 187 recommend creating best practices and training for completing medical certifications, completing death investigations and filling out death reports. We heard throughout our meetings the importance of filling out a death record properly and how it seems that there is a disconnect with the medical world and the world of medical examiners and coroners. Establishing best practices would be a step towards uniformity across our 72 counties.

Lastly, AB 188 would officially recognize fatality review teams under state law. Currently, 45 counties in Wisconsin have created their own fatality review teams to help gather data and information on

PO Box 7882 • Madison, WI 53707-7882
(608) 266-7511 • (888) 437-9436 • Sen.James@legis.wisconsin.gov • www.SenJesseJames.com

overdose deaths, child deaths, suicide deaths, as well as others. This bill helps implement parameters and scopes for these review teams, as well as protect the sensitive, confidential data they deal with.

Death can be a heavy subject, and collecting this information can be sensitive and difficult. We need to help those who are obtaining this data by making sure the system they are using is functioning properly and efficiently, which will then help with identifying overall issues and trends. Creating a uniform standard for this industry can change what type of data can be collected, what we can learn from it, and most importantly, how we can change it for the better. Thank you, and I will happily take any questions at this time.

Respectfully,

Senator Jesse James
23rd Senate District
Sen.James@legis.wisconsin.gov

State of Wisconsin
Department of Health Services
Tony Evers, Governor
Kirsten L. Johnson, Secretary

TO: Members of the Assembly Committee on Health, Aging and Long-Term Care

FROM: HJ Waukau, Legislative Director

DATE: August 10, 2023

RE: Legislative Study Committee on Uniform Death Reporting Standards Bills

The Department of Health Services (DHS) would like to submit testimony for information only on the bills put forward by the Legislative Study Committee on Uniform Death Reporting Standards (UDRS). DHS appreciates its collaboration with the UDRS Committee and the opportunity to provide feedback on all of the bills as they were being drafted and deliberated. Additionally, DHS would like to thank the UDRS Committee members for accepting a significant amount of DHS' feedback and for putting forward a package of bills that will help to update the death reporting and vital records processes. Six bills in all were drafted by the UDRS Committee with five directly impacting DHS operations and the Statewide Vital Records Information System (SVRIS). DHS takes no issue with AB 184, AB 186, or AB 187 as currently drafted; and AB 189 does not impact DHS operations. However, DHS recommends that AB 185 and AB 188 be amended to provide resources for DHS to carry out the tasks enumerated under both bills and to allow for a more efficient use of resources.

DHS testified twice in front of the UDRS Committee during its deliberations over the latter half of 2022. DHS' first testimony focused on delivering an overview to the Committee on the functions of the State Vital Records Office (SVRO), what constitutes a vital record, and the death records process.[1] This overview was provided at the request of the Committee Chairs and was intended to provide a foundation for all Committee members for their subsequent deliberations. In its second hearing, also at the request of the Committee, DHS presented on the state's interactions with the National Violent Death Reporting System (NVDRS) and State Unintentional Drug Overdose Reporting System (SUDORS); which are used to track violence-related and overdose deaths.[2]

AB 185 as drafted would require any person who completes and signs a medical certification to use the electronic system of vital records to complete the certification as required under law while eliminating the option to mail a death record to the filing party. Under AB 185 certifiers filing death records would no longer be allowed to use a "fax attestation form" as is allowed under existing law. Nationwide, 21 jurisdictions have some sort of requirement for electronic medical certification. Moving to an electronic records transfer system would require significant system upgrades and staff support to prepare for the additional users. Currently, all Wisconsin funeral homes, coroners, and medical examiners use the electronic system to file death records, while a majority of physician-submitted records are done via the fax attestation process.

---

[1]2022 Legislative Council Study Committee on Uniform Death Reporting Standards, "Presentation by Lynette Childs, State Registrar, State Vital Records Office, and HJ Waukau, Legislative Director, Department of Health Services," Wisconsin State Legislature, July 18, 2022, https://docs.legis.wisconsin.gov/misc/lc/study/2022/2407/010_july_18_2022_10_00_a_m_room_411_south_state_capitol/july18_dhs_presentation.

[2]2022 Legislative Council Study Committee on Uniform Death Reporting Standards, "Presentation, National Violent Death Reporting system (NVDRS), by Lindsay Emer, PhD, NVDRS Coordinator, Wisconsin Department of Health Services (October 17, 2022)," Wisconsin State Legislature, October 17, 2022, https://docs.legis.wisconsin.gov/misc/lc/study/2022/2407/030_october_17_2022_10_00_a_m_room_411_south_state_capitol/oct17presentation_dhs_1.

In 2022, 8.8 percent of all medical certifications performed by physicians in Wisconsin were filed electronically using SVRIS. Utilizing the number of unique physicians that signed death certificates last year as a baseline, it is estimated that AB 185 would result in a net increase of over 5,000 new SVRIS users, equating to a 142 percent increase over the current user base. To account for this increase DHS would need 4.0 new full-time equivalent (FTE) positions, under the Information System Business Automation—Senior classification, at a cost of $338,188 in program revenue annually to implement the requirements of AB 185. Two positions would be required to serve as system trainers for new users, maintain and perform ongoing training refreshers for established users, maintain end user documentation, and develop and maintain end user policy support. The other two FTEs would extend the capacity of existing analysts to meet the needs of the additional system users expected under this bill. Currently the SVRO has 5.0 FTEs to support existing program demands. States like South Carolina, Iowa, and Minnesota have similar programs as would be created under AB 185 and have supporting staffs of 8-to-10 FTEs. Funding to cover the increased staffing and costs would be covered by program revenue from fees appropriated under Wis. Stat. § 20.435(1)(gm) and assessed by SVRO. No new GPR funding would be needed.

AB 188 creates a new structure for fatality review teams in Wisconsin. Currently, fatality review teams operate in an ad hoc manner and there is no specific statutory authority related to fatality review teams. Rather there are only general provisions around confidentiality of records, access to records, and surveillance of public concerns. AB 188 would formalize this process by requiring DHS to establish a statewide fatality review program and permit DHS to create a statewide fatality review team. AB 188 would also define the duties, obligations, and structures of fatality review teams; the types of deaths to be reviewed; potential team members; and confer rulemaking authority on DHS for the development of the fatality review program. To help implement the provisions of AB 188, 4.0 new FTEs at a cost of $317,223 GPR annually will be needed to satisfy the new programming requirements created by the bill. The four positions recommended by DHS would be as follows:

- *Human Services Program Coordinator:* who would be responsible for the overall coordination and oversight of the program, including supporting existing teams and providing support for new teams.
- *Program and Policy Analyst:* who would be responsible for supporting state and local teams and would lead dissemination of data and reports to stakeholders outlined in the proposal.
- *Public Health Educator:* who would support the Human Services Program Coordinator and Program and Policy Analyst in information dissemination and using findings from review teams to implement new best practices.
- *Epidemiologist Advanced:* who would support data needs of local teams, perform quantitative and qualitative analysis, and synthesize technical data for lay use.

Additionally, DHS recommends that maternal deaths also be added to the list of eligible deaths that could be investigated by the proposed Fatality Review Team program under AB 185. DHS currently reviews maternal deaths on an ad hoc basis utilizing federal funds. Adding maternal death reviews to the Fatality Review Teams' list of parameters would provide better alignment and structure, be a more efficient use of resources, and ensure this important work can continue.

Regarding the recommendations for both AB 185 and AB 188, DHS made similar recommendations to the UDRS Committee in writing, as the Committee debated the legislative proposals at its November 2022 and December 2022 hearings. In its comments to the UDRS Committee, DHS noted that it generally agreed with the concepts being advanced by the Committee, but resources would be necessary to implement the provisions of the bills.

DHS thanks the Assembly Committee on Health for the opportunity to submit testimony for information only on the UDRS Committee's package of bills. DHS is also appreciative for the significant amount of collaboration with the UDRS Committee and in that spirit would like to continue efforts to ensure the proposals contained in the bills can be put into effect.

Children's Wisconsin

TO: **Assembly Committee on Health, Aging & Long-Term Care**
FROM: **Jodi Bloch, Director, State & Local Government Relations**
DATE: **Thursday, August 10, 2023**
RE: **Support for Legislative Council Study Committee on Uniform Death Reporting Standards legislation**

Chairman Moses and members of the committee, thank you for the opportunity to share written remarks with you today. Children's Wisconsin would like to acknowledge Senator Ballweg and all the members for their dedicated work on the Legislative Council Study Committee. My former colleague, Karen Ordinans, who has years of experience leading a child fatality review initiative and worked to inform the Study Committee's work, and Libbe Slavin, who leads the SafeKids statewide coalition lead by Children's, will share their strong support for AB 188. I also wanted to share Children's general support and feedback on the other pieces of legislation in this package.

Children's is the region's only independent health care system dedicated solely to the health and well-being of kids. As such, we offer a wide array of programs and services inside our hospital and clinic walls and out in our communities aimed at preventing injury and keeping kids and their families healthy, well and thriving. Our highly specialized teams are there for children and their families during some of their hardest moments, including, tragically, the heartbreaking experience of losing a child. Our trauma, emergency department and critical care teams offered their feedback on the legislation outlined below.

AB 185 – Requiring use of electronic system of vital records for medical certifications of death
Our team is supportive of an electronic system for certificates of death. We believe this would improve accessibility, streamline the process and hopefully reduce redundancies. We recommend ensuring that interoperability with electronic health records be explored to facilitate efficiency and not duplicative/separate processes.

AB 186 – Recommended training for signing medical certifications of death
Children's believes this legislation would help support consistency and accuracy of death data. This would be helpful for providers new to Wisconsin as well as for standardizing education for trainees. Access to training materials may help eliminate inconsistencies and confusion when filling out forms to ensure timely completion.

AB 187 – Requiring DHS to establish and encourage best practices for coroners and medical examiners
Our team supports the development of best practices and resources to support enhancing their practice.

AB 188 – Fatality review teams
We refer to the remarks shared by Karen Ordinans and Libbe Slavin outlining our shared support for this legislation.

AB 189 – Requiring notification of any death within 24 hours
Children's reports all death within one hour, so while this would not impact our practice, agree with the support for timely, accurate data on reportable deaths.

Thank you for the opportunity to share Children's Wisconsin's support for this legislation. I am happy to work with the Children's team to answer any questions through my contact information listed below.

Jodi Bloch
Director, State & Local Government Relations
Children's Wisconsin
608-217-9508
jbloch@childrenswi.org

WiHPCA

Moving Wisconsin Hospice & Palliative Care Forward

TO: Honorable Members of the Assembly Committee on Health, Aging and Long-Term Care

FROM: Jennifer Flugaur
Vice President of Clinical Excellence, Agrace
on behalf of the Wisconsin Hospice & Palliative Care Association (WiHPCA)

DATE: August 10, 2023

RE: Concerns regarding Assembly Bill 189, related to requiring notification to the medical examiner or coroner of any death that occurs within 24 hours of presentment at or admission to certain facilities

---

Good morning, Chair Moses, Vice Chair Rozar, Ranking Member Subeck, and members of the Assembly Committee on Health, Aging and Long-Term Care.

My name is Jennifer Flugaur, and I am the vice president of clinical excellence at Agrace, which is a nonprofit, community-based health care agency; I have been a hospice nurse for 15 years. Agrace provides hospice and supportive care services in private homes, and in skilled nursing, assisted living and other community based residential facilities across southern Wisconsin. Agrace is a member of WiHPCA – the Wisconsin Hospice and Palliative Care Association. We appreciate Chair Moses for holding a hearing today on Assembly Bill 189.

As someone who interfaces regularly with medical examiners and coroners, I am here today to share WiHPCA's concerns regarding Assembly Bill 189. This bill requires all individuals or organizations that are currently required to report certain deaths to medical examiners or coroners to also notify these officials of ALL persons who have died within 24 hours of admittance or presentment to a hospital or other facility (including a hospice) – even deaths not currently included under existing reportable circumstances in section 979.01 of Wisconsin state statute. WiHPCA is seeking a partial exemption for hospice agencies, as a substantial percentage of deaths occur within 24 hours of admission to a hospice facility. More specifically, WIHPCA is seeking an amendment exempting hospices from notifying medical examiners or coroners of any deaths not included under existing reportable circumstances in section 979.01. In other words, we would like current law to remain in place and continue to report to the medical examiner or coroner deaths that only meet the circumstances in section 979.01(1), regardless of when they occur.
In 1982, Congress approved Medicare reimbursement for hospice care services, and with that the Medicare Hospice Benefit was born. The Federal Hospice Conditions of Participation (COPs) came to be shortly thereafter in 1983, and at their core have remained relatively unchanged. Embedded within those COPs includes eligibility criteria, which states that certification for hospice comes from up to two physicians who must certify that the patient has a prognosis of 6 months or less, should their illness run its normal course.

As referenced above, under Wisconsin state statute section 979.01, there are deaths that are automatically reported to the coroner or medical examiner; additional and more stringent rules may vary by county. Included in these mandated reporting rules are notifying the coroner or medical examiner of certain types

of death, regardless of hospice eligibility. Reportable deaths include, but are not limited to, homicides, suicides or deaths following accidents. The most common type of reportable death that we see in our hospice population are those deaths following an accident, typically a significant fall. Agrace and all hospices across Wisconsin follow these rules. It's also important to note that hospice nurses in the state of Wisconsin can pronounce deaths per Wisconsin state statute section 69.18. Per this statute, a hospice nurse in a hospice directly involved in the care of a hospice patient who dies may pronounce the date, time and place of the patient's death under certain circumstances, including that the patient was generally under the care of a physician at the time of death and that the death was anticipated.

Agrace owns and operates two inpatient units—one in Dane County which has 50 beds and a 12-bed unit in Rock County. Between those units, we admit approximately 950 patients/annually to general inpatient (or acute) care. Approximately 20% of those patients die on the same day or the day immediately following their admission to the facility. If Assembly Bill 189 becomes law, that would significantly increase the number of deaths that need to be submitted to the medical examiner or coroner. Each report requires a specific process that I will describe below.

In a majority of cases requiring a call to the coroner or medical examiner, a series of questions is asked of the hospice nurse or nurse-designee who pronounces the death of the patient. This call can last upwards of 15-30 minutes and may involve numerous touches between the RN and the coroner or medical examiner. Questions can be very detailed and may include a request for a detailed history of any chronic medical conditions (sometimes going back decades), whether or not the patient had a history of depression or previous suicide attempt(s), circumstances surrounding the death, including when the patient was last seen alive. In the case of a fall, questions will be asked specific to the fall, including circumstances on whether the fall was witnessed and whether the patient received medical treatments for their injury and what treatment included. Often times, the record may not be inclusive of all the details needed for the coroner or medical examiner, so the nurse then needs to ask the family questions. No matter how sensitively these questions are asked, they may cause significant trauma to family members during a time when they are grieving the loss of their family member.

More times than not, even after dialogue with the coroner/medical examiner, the deaths for hospice patients are considered "natural" and the body is released, so the chosen funeral home can be called. The calls to the coroner or medical examiner, while required, place a significant burden on the hospice nurse, removing them from the bedside and away from the family who may need additional supports following the death of their loved one.

I'll end with a story, and while the details have been slightly changed to protect patient privacy, it is not one that is uncommon.

Elizabeth is a patient admitted to hospice care in her home in February. She is 45 years old. A wife, mother of three children: 15, 12, and 7. Just prior to her admission to hospice, her oncologist shared with her that treatments for her metastatic breast cancer were no longer available. Elizabeth made the decision with her husband that she wanted hospice support at home, not only to manage her worsening symptoms as a result of metastatic breast cancer, but to provide education and support for her husband and young children who would soon be faced with the reality of losing their wife/mother. The hospice team visited Elizabeth in her home, ordering medications and durable medical equipment. Elizabeth and her family knew she was dying. It became apparent that it was very important to her to remain home as long as she could, but it was also very clear that she did not want to die in the home where her children would continue to grow up. For them, she wanted happy memories, and didn't want the vision of her deceased

body to haunt her children each time they passed the room where her hospital bed was placed. Early July came and Elizabeth's condition continued to worsen. She became increasingly tired, suffered from increased pain, as a result of her bone metastases, and was able to tolerate very little food intake. She relied on oxygen so as to not become short of breath with little to no exertion. The decision was made with Elizabeth's family to honor her wish and transition her to a hospice inpatient unit. She arrived at the facility via ambulance at 5:00 PM with her family at her bedside. Her children had one final "sleep over" bedside with their mom, Elizabeth, who woke only briefly to smile. She died, comfortably, at 8:00 AM the next day, having been a patient in the inpatient unit for only 15 hours. The nurses leapt into action, providing support to Elizabeth's family, working to provide closure, recognizing it would be the last opportunity her kids would have to spend with their mom.

Elizabeth's death could not have been any more expected. Had Assembly Bill 189 been in place at the time of her death, staff would have spent their time on the phone with the coroner or medical examiner, instead of with the family-at a time when they needed support the most.

Hospices recognize the importance of the involvement of the medical examiner and coroner, but please do not take our staff further away from the bedside, nor add to the burdens of our county medical examiners and coroners to be involved in deaths that are expected and without need for additional investigation.

Thank you for your time and consideration of WiHPCA's concerns and our request for a hospice exemption to Assembly Bill 189. Please contact WiHPCA's government relations representatives, Tim Hoven (at 414.305.2011 or tim@hovenconsulting.com) or Nathan Butzlaff (at 608.310.8833 or nathan@hovenconsulting.com) if you have any questions or need additional information.