Wisconsin Legislative Council
STUDY COMMITTEE MEMO

Memo No. 3

TO: MEMBERS OF THE STUDY COMMITTEE ON UNIFORM DEATH REPORTING STANDARDS

FROM: Amber Otis, Senior Staff Attorney, and Kelly McGraw, Staff Attorney

RE: Options for Committee Consideration

DATE: October 10, 2022

This memo provides a nonexhaustive list of options for consideration and discussion by the Study Committee on Uniform Death Reporting Standards. Specifically, the options presented are based on issues raised by presenters and committee members during the committee's first two meetings. This memo may assist the committee in determining which options, if any, to request be prepared as a preliminary bill draft for the committee's review at its next meeting.

VITAL RECORDS AND STATISTICS

Types of Data Collected by State Vital Records System

Background

State law requires the Department of Health Services (DHS) to establish an office of vital records and appoint a state registrar, who must act as custodian of, and direct a system of, vital records, including death records. Current law requires that a death record contain all of the following information:

- Fact-of-death information, which must include: the decedent's name and other identifiers; the date, time, and place that the decedent was pronounced dead; the identity of the person certifying the death; and the dates of certification and filing of the death record.
- Extended fact-of-death information, which includes fact-of-death information, as well as information on final disposition, manner, and cause of death, and injury-related data.
- Statistical-use-only information, which includes any other information collected on the standard death record form recommended by the federal agency responsible for national vital statistics,[1]

[1] The Center for Disease Control and Prevention (CDC) is the federal agency responsible for national vital statistics and publishes this form. The Wisconsin vital records system collects all the same data points contained in the CDC form, and is designed to flag if submitted information is unacceptable or acceptable for a specific type of field. Many of those data points are reflected in the state law requirements, though the form does include some additional fields, such as identifying the decedent's occupation and stating whether the decedent was ever in the U.S. armed forces.

along with any other data as directed by the state registrar, including race, educational background, and health risk behavior.

[ss. 69.02 (1) (b), 69.03, and 69.18 (1m), Stats.]

The person filing the death record, commonly a funeral director, completes many portions of the death record, but the person who signs the medical certification portion of the death record must describe the cause of death and also show the duration of each cause, the sequence of each cause if the cause of death was multiple and, if the cause was disease, the evolution of the disease. If a coroner or medical examiner is signing the medical certification, he or she must describe any violence related to the cause of death, its effect on the decedent, and whether the manner of death was accidental, suicidal, homicidal, or undetermined. [s. 69.18 (2) (f), Stats.]

Options

Based on testimony and discussion, the committee could consider the following options:

- Modify or expand the types of data reported by individuals medically certifying the cause and manner of death.
- Modify or expand the types of data reported by the party filing the death record with the State Office of Vital Records (SVRO).

For these options, the committee may wish to address the following questions:

1. What types of data would be added or modified?
2. Which category of the death record listed above (fact-of-death, cause-of-death, or statistical-use-only information) would be affected?
3. Would the collection of new data fields be required or optional?
4. Would changes to death record data occur by modifying state statute or by requiring DHS to promulgate administrative rules? If the latter, should such legislation identify the additional data fields to be collected, or direct DHS to determine such fields consistent with a specified purpose or scope?
5. If new data fields are added, should the current law provisions governing timelines and disclosure be modified?

Method of Collecting of State Vital Records Information

Background

Death record data is typically submitted electronically to SVRO using the Statewide Vital Records Information System (SVRIS). This process commonly begins with a funeral director initiating the record in SVRIS and collecting data from various sources – namely the decedent's family – and then selecting a physician, coroner, or medical examiner to medically certify the cause and manner of death. Once the cause and manner of death is medically certified, the death record is returned to the funeral director, who then signs and routes the death record to the local vital records office. The local vital records office accepts the death record and it is then registered with the SVRO. While this process can occur electronically, the use of paper forms sent via facsimile remain a common practice in some contexts.

Based on testimony and discussion, the committee could consider the following options:

- Clarify the ability of SVRO to communicate directly with other government agencies, who may have relevant information relating to death record data, such as veteran military status, that could be directly input into SVRIS.
- Require or advise the use of standardized forms or software systems, so as to streamline data collection.

For these options, the committee may wish to address the following questions:

1. To the extent government agencies have information relevant to death record data, how would communication among those agencies and SVRO occur?
2. What types of forms or systems would best support streamlining data collection?

Medical Certification of Cause and Manner of Death

Background

Current state law generally requires that the cause and manner of death be medically certified by a physician, coroner, or medical examiner, but does not require any type of training on how to properly certify a decedent's cause and manner of death. To this end, professional associations have generated sample checklists in the past, and the CDC publishes handbooks on death registration by physicians, medical examiners, and coroners. The committee members heard testimony that varying approaches to certifying cause and manner of death may exist throughout the state.

Options

Based on testimony and discussion, the committee could consider the following options:

- Require, advise, or incentivize training on how to properly certify cause and manner of death.
- Require, advise, or incentivize use of certain tools, such as standardized forms or checklists, when certifying cause and manner of death.

For these options, the committee may wish to address the following questions:

1. Would completion of training or use of a tool be required or recommended?
2. Which professionals would be required or advise to complete or use any such training or tool? If any requirement or recommendation is applicable to all individuals authorized to certify cause and manner, would the content for such training or tools differ depending on the individual's role (e.g. physician, coroner, or medical examiner)?
3. Who would determine the proper resource and/or content for such training or tools?
4. If any new training or tools are required or recommended, should such directives be created by state statute or administrative rule?

Data Collection Beyond Vital Records

Background

The committee has heard testimony regarding efforts in Wisconsin and other states to collect, beyond vital records, various types of data related to deaths. For example, a majority of states, including

Wisconsin, submit data to the National Violent Death Reporting System, which collects data not only from vital records but also from other sources, such as law enforcement records and reports from the coroner or medical examiner.

Other efforts have been made in Wisconsin and elsewhere to gather information beyond that which is submitted to national statistical databases. For example, in Winnebago County, a coalition of public health, law enforcement, mental health advocates, coroners, and medical examiners have created and implemented the use of a suicide investigation form that includes questions related to various topics, with the goal of identifying future prevention efforts. Also, Colorado has created an extensive suicide investigation form to guide conversational interviews with a decedent's family and friends. Colorado's state health department has published that form on its website and administers a mini-grant program to incentivize counties to use the form. In another example, Utah's centralized Office of Medical Examiner conducts next-of-kin interviews following suicide deaths and gathers information using a standardized form.

Options

Based on testimony and discussion, the committee could consider the following options:

- Create a new standardized form or process that allows coroners and medical examiners to simultaneously submit data to vital records and the National Violent Death Reporting System.
- Recommend or require creation and use of a suicide investigation form statewide.
- Recommend or require use of next-of-kin interviews statewide.
- Create a pilot program in specified counties that would require use of either of the options above.
- If recommended, rather than required, create incentives for counties to use a form, interviews, or both.

For these options, the committee may wish to address the following questions:

1. If a form or interview is recommended or required, what types of questions or data fields should be included and who would be tasked with completing the form or interview?
2. How would the data or information received in either a form or interview be shared or used for prevention efforts or other statistical purposes? Who would receive the information collected?
3. If a pilot program is created, how would be counties be selected? How would analysis of the pilot program's outcomes be conveyed to the Legislature and/or the public?
4. Which aspects of a recommendation or requirement to collect data using a form and/or interview are best suited for state statute versus administrative rule?

Fatality Review Teams

Background

Wisconsin does not have a state law governing any type of fatality review team. However, approximately 45 counties have opted to create fatality review teams. Several types of fatality review teams exist in Wisconsin, such as child death review teams, fetal infant mortality review teams, overdose fatality review teams, and suicide review teams. Though each county's approach may vary, teams generally consist of local professionals from various disciplines, such as law enforcement, a coroner or medical examiner, and public health. These teams typically meet regularly in a confidential setting to discuss

individual death incidents, with the goal of identifying and discussing risk factors and circumstances surrounding the death, so as to inform future prevention strategies. Many teams complete a data form regarding the incident. For example, many Wisconsin child death review teams complete the form available here and provide it to the National Center for Fatality Review and Prevention for inclusion in the Child Dynamic Analysis and Statistics Hub (Child DASH), an online portal with de-identified death information that can be analyzed to inform prevention efforts.

Options

Based on testimony and discussion, the committee could consider the following options:

- Create a state statute governing local fatality review teams.
- Create a state statute governing a state fatality review team.
- If use of local fatality review teams remains optional, create incentives for counties to create such teams.

For these options, the committee may wish to address the following questions:

1. Would a state statute governing local fatality review teams require a county to create a fatality review team or, alternatively, create a framework for counties that opt to create a fatality review team?
2. Would a governing statute apply generally to all types of fatality review teams or only specific types of teams?
3. How would a governing statute address, if at all, a team's definition, structure, composition, tasks, and work product? Would a local team's work be overseen or supported by any state agency, such as DHS?
4. Would a local or state team's work product include submission of a data form? Would such a data form be required or recommended? To whom would that form be submitted, and what types of information would be included in the form?
5. How would a governing statute address, if at all, the collection, storage, and disclosure of information? For example, would the statute clarify a team's ability to access records, a team's confidentiality or ability, if any, to disclose information, or other current practices related to information gathering and use by fatality review teams in Wisconsin?
6. Would a governing statute address all aspects of a local or state team's functions, or would relevant state agencies be directed to promulgate rules governing certain aspects of a team's functions?
7. In what ways could a county be incentivized to create local teams, if such teams were recommended, rather than required?

Please let us know if we can provide any further assistance.

AO:KAM:ksm