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.

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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.

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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

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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.

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[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.

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

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Kids deserve the **best.**

TO: Members of the Assembly Committee on Health

DATE: August 10, 2023

RE: Support to AB 188/SB 177 – Fatality review teams

From: Safe Kids Wisconsin, led by Children's Wisconsin

Safe Kids Wisconsin is a member of Safe Kids Worldwide, a network of over 400 local coalitions in the U.S., including 11 in Wisconsin which are included on the attached map. These coalitions work throughout the world bringing together health and safety experts, educators, corporations, foundations, governments and volunteers to educate and protect families. Our mission is to prevent childhood injuries, the leading killer of children 0-19.

Each of the 11 local coalitions in Wisconsin are led by different partners including local hospitals, health departments and other organizations that all work toward keeping children healthy and safe. Members of the coalitions include local police and fire departments, hospitals, schools, churches and other community organizations that also work toward the unified goal of child safety just as the goal of multidisciplinary child fatality review teams.

We write in support of AB 188, which will codify current fatality review practices into state statute to ensure consistency and clarify across all counties within our state. Many of the current data sets used to drive injury prevention programming lack contextual information beyond the immediate cause of death. Child Fatality Review data provides additional invaluable information on the circumstance that can provide valuable insight to guide prevention efforts such as policy, legislation, environmental modifications and other educational and awareness efforts. This bill helps injury prevention professionals get to the key factors in child deaths to better guide effective prevention efforts.

The process of child fatality review can help communities have clearer understanding of underlying risk factors and inequities not found in other sources of data. Having review practices in state statute will provide this insightful data for evidence-informed strategies and the recommendations that come from the teams will be much more likely to have an impact particularly where organized coalitions like Safe Kids is there to support implementation.

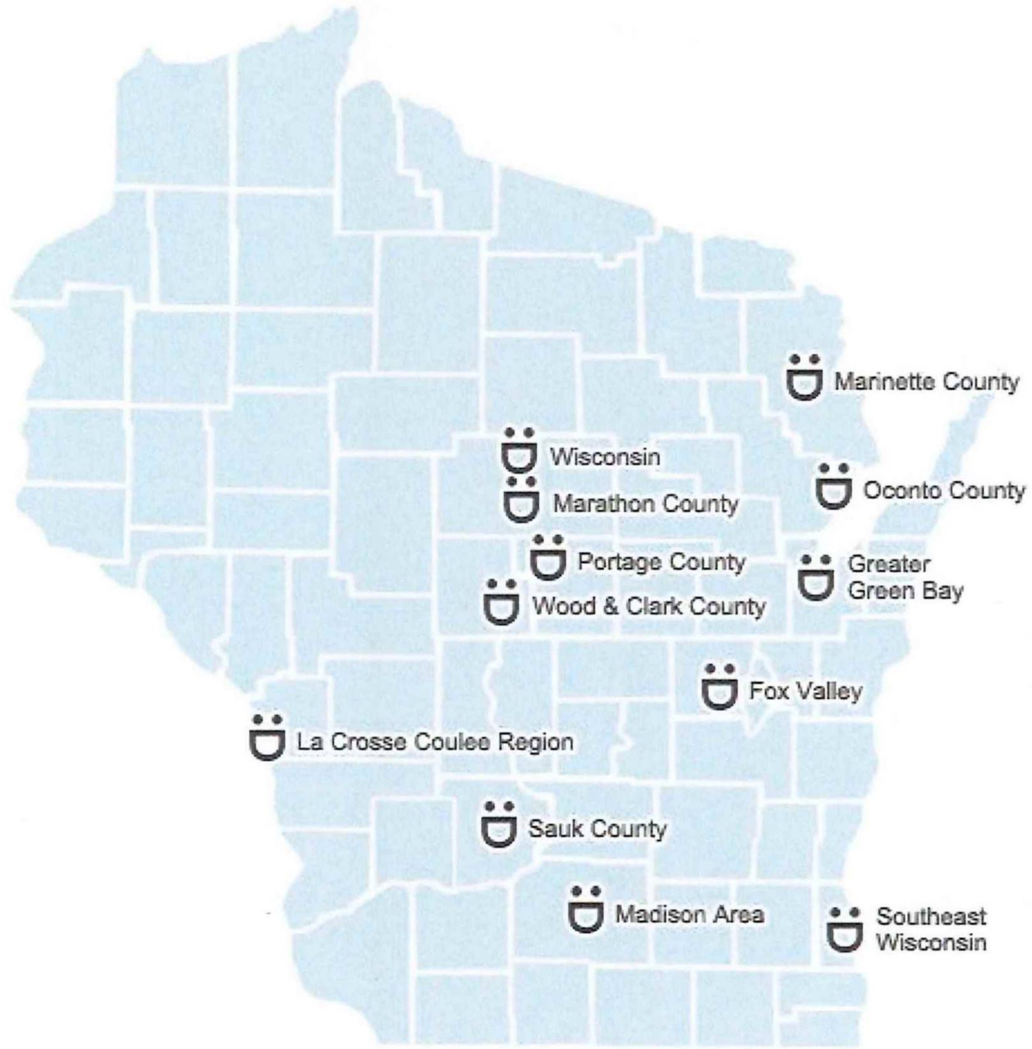
We ask the committee members to support this legislation which will save lives. Losing one child is one too many, and don't want any parent to have to endure the loss of a child. Please feel free to contact me with any follow up questions at LSlavin@childrenswi.org or visit www.safekidswi.org to learn more about the work of the local coalitions.

Sincerely,

Libbe R. Slavin

Libbe Slavin
Program Manager
Safe Kids Wisconsin, led by Children's Wisconsin

Safe Kids Wisconsin Local Coalition Map



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

FROM: **Constance Kostelac, PhD**
Assistant Professor
Institute for Health & Equity, Division of Epidemiology & Social Sciences
Director, Division of Data Surveillance and Informatics, Comprehensive Injury Center
Medical College of Wisconsin

Sara Kohlbeck, PhD, MPH
Assistant Professor, Department of Psychiatry and Behavioral Medicine
Director, Division of Suicide Research and Healing, Comprehensive Injury Center
Assistant Director, PhD Program in Public and Community Health, Institute for Health and Equity
Medical College of Wisconsin

DATE: **August 10, 2023**

RE: **Testimony in Support of Assembly Bill 188, Related to Fatality Review Teams and Granting Rule-Making Authority**

The Medical College of Wisconsin (MCW) supports Assembly Bill 188 (AB 188), related to fatality review teams and granting rule-making authority, and respectfully requests your support for this important legislation. AB 188 will create a formal framework for fatality review teams under state statute, clarify the fatality review process, eliminate current barriers in sharing information that is critical to conducting fatality reviews, and among other provisions, will ensure voluntary participation and confidentiality of data.

Enacting AB 188 will ensure policymakers better understand why various types of fatalities occur throughout Wisconsin, including within specific geographic regions of the state, helping better inform how to take steps to prevent similar deaths in the future.

The Institute for Health & Equity at MCW is focused on researching the root causes of health disparities in our communities and advancing the best practices to foster health equity throughout the world and through the Division of Epidemiology & Social Sciences, is focused on finding answers to violence, substance use, and other public health threats that have not traditionally been viewed through the same lens as disease. MCW's Comprehensive Injury Center's vision is a healthier and safer community for all. Injury is a biopsychosocial disease that presents a lifelong risk of premature death and disability. Unintentional injury is the leading cause of death among individuals ages 1 through 44 in the United States and unintentional injury (e.g., homicide and suicide) is a leading cause of death among individuals ages 10 to 34.

The MCW Comprehensive Injury Center and the Institute for Health and Equity provide significant scope and research capability as it relates to advancing fatality review work across the state. The Division of Suicide Research and Healing currently convenes a statewide community of practice of suicide review teams, which recently published a guidebook for suicide review in Wisconsin. Members of the Division of Data Surveillance and Informatics and the Institute for Health and Equity facilitate local review teams focused on prevention of deaths due to homicide, including domestic violence and child homicides. In addition, they provide training and technical assistance to local teams across the state conducting overdose fatality reviews, as contracted by both the Wisconsin Department of Justice and the Wisconsin Department of Health Services. They also staff the Overdose State Advisory Group, which is comprised of key state agencies and other partners focused on reducing overdose fatalities across Wisconsin.

This legislation will be transformative for fatality review teams across Wisconsin. Fatality review relies on the sharing of information related to deaths under review in order to inform a comprehensive and more complete discussion of the antecedents to these deaths. It is important to note that in most cases, these non-natural deaths are preventable, and a comprehensive review of the factors preceding these events is critical to informing and taking steps to prevent additional loss of life.

By facilitating an environment of information sharing for the purposes of fatality review, policymakers have an opportunity to contribute to this work of prevention. Dr. Kohlbeck has been involved in fatality review in various counties across the state, including Milwaukee County, Fond du Lac County, and Winnebago County. Additionally, she served on the Legislative Study Committee which recommended this legislation. Dr. Kostelac and her team facilitate local reviews on homicide and overdose and providing training and technical assistance to 24 local teams conducting overdose fatality reviews across the state (https://www.mcw.edu/ofr), as well as an internal team with the Department of Corrections, Division of Community Corrections. They have both observed differences in how counties currently interpret the permissibility of data sharing for purposes of fatality review, which ultimately leads to variability in data available for prevention across Wisconsin. In their roles as training and technical assistance providers, Dr. Kohlbeck and Dr. Kostelac have heard directly and regularly from local teams that there is a shared need for legislation that clarifies the development and operation of fatality review teams. By enacting this legislation, we would be helping to eliminate this variability while allowing teams to work with their partners to gather more comprehensive data.

As additional counties are involved in fatality review, we have an opportunity to augment the surveillance data that is already available about these non-natural deaths. While the surveillance data that is currently available to prevention organizations provides critical information on numbers and trends at the state level, this is just one piece of the puzzle. It does not provide detail on the factors that cause or lead to these deaths nor does it often provide the level of detail necessary to identify the gaps that can be closed to help prevent similar deaths from occurring in the future. This is the important work of fatality review; with the information gained from fatality review, bolstered by this legislation, we can be more targeted in our prevention efforts, tailoring these efforts to the communities we all serve. Ultimately, this work will save lives.

Thank you for your consideration. MCW respectfully requests your support for this legislation. Please feel free to contact Nathan Berken, Interim Vice President of Government and Community Relations, at 414.955.8217, or nberken@mcw.edu, if you have any questions or would like additional information.

Good morning chairman and members of the committee.

My name is Teresa Paulus. I am a recently retired registered nurse. My former position was as a public health nurse at Winnebago County Health Dept for 33 years.

I am here to give testimony in support of Assembly Bill 188

I have been deeply involved in fatality review: I initiated the Child Death Review (CDR) Team in Winnebago County and served as the chairperson for 14 years. I served on the National Advisory Board for CDR. I assisted in the development of the overdose and suicide review teams in Winnebago county. I also was a member of the study committee that recommended this Bill. Why so involved? I lost my 3-year-old son, Brian, to a drowning. It could have been prevented. I couldn't save Brian, but I could help save other children and prevent the devastating grief for other families. Pain was to the point I didn't want to go on. It has taken over 20 years to learn how to live with the loss and still the pain breaks through. It is very difficult to feel happiness. Doing this work has sustained me.

I support Assembly Bill 188 because it is necessary to save lives and the concept has already been in place and worked with the Child Death Review Program through the Childrens Health Alliance of Wisconsin

First let me mention the goals of fatality review:

-Form a team of members from multidisciplinary roles to collaborate in a confidential setting about deaths with the end goal to prevent further deaths. This will also help to improve members own functioning and collaboration as they see fit.

-Identify risk factors and circumstances surrounding deaths and translate into data that will lead to prevention of injuries and death.

-Influence policies and programs that promote and improve safety.

-Allow collaboration between state and local teams which will improve function of teams and promote sharing prevention efforts to save lives.

-Promote grief support for families which will further save lives. (Loss of a loved one is a risk factor for suicide)

Why is legislation needed?

Establish recognized fatality review teams in Wisconsin to prevent deaths.

Without these teams, deaths go unrecognized, trends are not realized, prevention is not addressed, and more people die. I have seen the struggles of individual teams trying to start up with no reference point. I have seen communities want to start a team but can't because they don't have time, or they don't know how. Recognition of a team brings respect and trust to a team, and they are then looked to as a valuable resource.

Clearly define the purpose, structure and confidentiality of the fatality review process. Provide clarity and uniformity across fatality teams in Wisconsin.

I have seen the efficiency of the State Child Death Review Program in Wisconsin. It provides an organized home for guidance, standards, steps, and education in starting and running a team. This was provided to me as I started and led the Child Death Review Team in Winnebago County. Our overdose and suicide review teams referenced the CDR materials, and with my experience, it helped them initiate and run a team. In addition, prevention measures can be shared among teams which is efficient to promote death prevention and prevent "recreation of the wheel."

Resolve barriers that many local review teams experience.

Confidentiality can be a barrier, but with legislation this can give agencies reassurance that what they are sharing is admissible and will be kept confidential. Public Health is allowed to share and receive health information about an individual for prevention efforts. Previously, our human services would not allow the review of any child protective service cases. Our team was then very limited on cases to review. Once human services served on the team and saw its function and confidentiality, they allowed these cases to be reviewed. In my 14 years, our team has never experienced a breach of confidentiality which allowed us to review deaths and develop and carry out recommendations. Relationships and collaboration among our members have improved. These teams are not about gossip, they are about a common goal of saving lives. Commitment and relevance is evidenced by the ongoing attendance and participation of my team and other teams. Even our coroner office is committed to participating. Sharing relevant information is crucial to saving lives. If not, people will die a preventable death.

Benefit to having fatality review teams in Winnebago County

Strong attendance at all fatality review teams is an indication of community support. Overdose deaths, suicide deaths, and child deaths in my community are being recognized and the trends are being realized. Before this, one would just read a news article about a death, and say, "too bad", or "that's sad" and move on without stopping to think about preventing the death. People always say to the griever "if there is anything I can do let me know" Well there is! Fatality Review! Grieving people don't want other people to die; they want to prevent others from going through the pain they are. Now, because of the fatality review teams, prevention is being addressed.

Examples of prevention recommendations from our CDR Team:

Through reviews, we identified the trend that motor vehicles injuries were the main cause of unexpected death in our youth. Team members researched and found a CDC program called Parents Are the Key which educates parents on how to teach safe driving to their kids. We collaborated with a local hospital and schools to present this to parents of 10th graders studying for their drivers permit. 100% of parents pledge to engage in a safe driving contract with their kids. We collaborated with Neenah High to start a teen led Safe Driving Team which provides activities for students to promote safe driving.

Death by Suicide became the number one cause of unexpected death in youth. Our CDR Team developed 11 Suicide Prevention Recommendations that were recognized and published by the Suicide Prevention Resource Center which is a federally supported resource in the U.S.. Also asked to present at state level and articles appeared in the local paper.

One of the recommendations was to develop a suicide review team which our health dept recently did.

Another recommendation was to develop a Standardized Suicide Death Review Form to guide coroners/medical examiners or other appropriate person to ask relevant questions of family, friends, others that will help identify risk factors and prevention recommendations. Our members developed this form as it lacked at a national, state and local level. Most families are receptive as its purpose of prevention is shared. This form has received inquiries from other teams in Wisconsin as well as other states.

A third recommendation was to develop education on Lethal Means Safety as most suicides were by firearm. We also knew that misuse of medication was a problem. Community members developed brochures for children and adults that addressed safe storage of firearms and medications.

Another area our team realized needed work on was Grief. There were conflicting views at schools on memorializing the child upon death, especially death by suicide. Members of our team and other community members developed guidelines; a policy which was very welcomed by the school districts. Another resource that was developed was a resource guide for parent grief. I could have used this as I was left alone to search for support and resources. I ended up travelling from Neenah to Milwaukee weekly to attend a child loss grief support group. Later, I was able to encourage the Center for Grieving Children in my community to start a parent support group.

Examples of recommendations by other fatality review teams in my county exist which I could gather and provide to you as requested.

I am quite passionate about fatality review. I wish there were recommendations out there to prevent my child's death. It is too late. What I can do is encourage you to support AB 188 to keep people alive and prevent the devastating pain of loss to family and friends.

Respectfully,

Teresa Paulus, RN
920-573-0937
jpaulus@new.rr.com

Testimony before the Assembly Committee on Health, Long term Care and Aging
August 10, 2023
Assembly Bill 188

Good morning, Mr. Chairman and members of the Committee,

My name is Karen Ordinans. I am the former executive director of Children's Health Alliance of Wisconsin, affiliated with Children's Wisconsin, who also supports this proposed legislation and has registered in support. While I am retired, I am here today because of my passion for this topic, and my history of being intimately involved in developing the child fatality review system that exists in Wisconsin today.

I want to recognize the detailed work of the Legislative Council Study Committee on Uniform Death Reporting Standards, chaired by Senator Ballweg. On behalf of the Alliance, I want to express our support for the recommendations before you today outlined in Assembly Bill 188.

As stated by Dr. William Perloff, the first chair of the state Child Fatality Review Council, and revered pediatrician, *"Nothing compares to the death of a child, in the sadness, the sense of loss, the unfulfilled promise. It reverses the natural order, and challenges our belief in a universal good."* When a child dies, we owe that child a collective and deliberate conversation to better understand what happened, why, and how we can prevent it from happening to another child.

Nearly 20 years ago the Department of Health Services (DHS) approached the Alliance and asked us to evaluate child fatality review programs in other states and create a plan for developing a comprehensive review program in Wisconsin that focused on prevention. Wisconsin was one of a handful of states without any review system. What we built had to make sense for our unique structure of 72 counties, with a mix of medical examiners and coroners, and strong local public health, social service and law enforcement systems.

The Alliance, in collaboration with DHS developed team protocols and training materials used by teams – better known as *Keeping Kids Alive in Wisconsin*. The Wisconsin model is based on recommendations developed by the National Center for Fatality Review and Prevention.

When we began there were only a few loosely organized review teams in our state. Today, there are 40 counties with formal organized fatality review teams. Unfortunately, however, this is down from 55 teams pre-COVID.

The Child Fatality Review teams exist to better understand how and why children die. They are multidisciplinary teams that meet, generally monthly or quarterly at the county level to discuss the risk factors and circumstances surrounding each unexpected death. Information is shared confidentially, and used to look at trends, gaps and needs. Prevention strategies are recommended by the team and are often implemented by a multitude of community partners with the intent to prevent other child deaths. The teams create collaboration across local agencies, and they allow for a greater understanding of each agency's functions and role.

Vital Statistics can tell us the cause "what the child died from" and manner "How the child died." But we need to better understand the why if we are going to prevent future deaths. For example, if there was a motor vehicle crash and the death certificate states cause of death as "blunt force trauma" and manner as "accident," we need to know more about the risk factors and circumstances present. Was the driver impaired? Were there icy roads or poor signage? Were the passengers properly restrained? As review team members come together, this is the information that is brought to light and leads to collaboration across agencies.

I would like to share several real examples of prevention efforts that have resulted from team reviews and data collection.

After reviewing multiple drownings, several counties implemented:

- Placing life jacket loaner stations near bodies of water that were open utilized by the public.
- Offering free swim lessons to children at community pools.
- Identifying unsupervised water access points and placing warning signs of dangers to the public.
- Incorporating water safety messaging in school communications and social media.
- Conducting listening sessions to solicit ideas from parents and children about how to raise awareness and share unique, creative ways to provide water safety education.

Through team reviews of car crashes a community recognized an increase in impaired drivers. This prompted partners to create a cost-effective and hands on learning experience. Yellow tape simulating road lines were applied to the school hallway and students attempted to walk and stay within the lines with eyewear that mimicked that of an impaired driver. Students were recorded and able to observe the outcome. Many were surprised to learn they performed more poorly than they thought.

Other activities included raising awareness about adhering to age-appropriate car seats, seat belts, and safe transportation for children and youth with special healthcare needs. And, educating new drivers about how inclement weather and other hazardous road conditions can contribute to motor vehicle crashes.

It was the work of review teams that led to a statewide infant safe sleep initiative. Data show more than 50 Wisconsin infants die each year with unsafe sleep risk factors present.

- Community and health professionals work together to raise awareness and educate families on the best and safest sleep practices, and are providing resources like Pack N Plays or Baby Boxes, and visual educational materials.
- The Alliance created training materials for counties and agencies to use as partners are working together to promote a uniform and consistent safe sleep message following the American Academy of Pediatrics Safe Sleep recommendations.

Review teams have also improved the understanding and communication between agencies. For example:

- Sheriffs' departments and other local law enforcement have modified death investigation protocols to capture important information on risk factors and circumstances.
- Law enforcement and hospital emergency department staff serving on a review team created a new and improved protocol for contacting parents after their child's death.
- As teams recognize the importance of providing support to families and professionals after a child death, many teams created grief support guides that explain what an autopsy report is; how to prepare for the funeral, and where to go for support for mental health needs that are sometimes brought on after a sudden loss.
- Other resources have been developed to educate professionals, funeral homes, medical examiners and coroners, first responders and others about how to support families grieving a child loss.

As part of the Alliance's Maternal Child Health Title V Contract with DHS, the Alliance continues to provide technical support to the local teams. This includes training and help in creating a team, ongoing guidance on the review of cases, data entry support, and prevention strategy support.

You may be wondering; if we've made great progress under the current system, why would we need state legislation? While we have made great progress, there also have been great challenges. We have 72 Corporation Counsels at the county level that interpret language differently. We have staff change and turnover at the local level and staff come with different levels of knowledge. Most importantly, over the years, we have had many local partners ask for clarity to be provided within one single state statute, rather than trying to cobble together the existing statutes which lends itself to differing interpretations and confusion.

The proposed legislation before you reflects current practices. Everything contained in the proposal is taking place among teams – but inconsistently. Passage of legislation will provide clarity and uniformity across Wisconsin. It will recognize established review teams and clearly define the team purpose and structure, while promoting prevention.

I am happy to provide additional information or answer any questions you may have. Your support of AB 188 would be greatly appreciated.

Thank you

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FATALITY REVIEW TEAMS BY COUNTY

Last modified - 11/14/2022

Specific review types are indicated by county, but it is important to note some counties have joint review teams that encompass more than one review type.

Douglas
Bayfield
Iron
Ashland
Washburn
Vilas
Burnett
Sawyer
Florence
Oneida
Price
Forest
Polk
Barron
Rusk
Lincoln
Marinette
Langlade
Taylor
St. Croix
Chippewa
Menominee
Dunn
Oconto
Marathon
Shawano
Pierce
Eau Claire
Clark
Door
Pepin
Kewaunee
Buffalo
Wood
Portage
Waupaca
Outagamie
Brown
Jackson
Trempealeau
Winnebago
Calumet
Manitowoc
Waushara
Adams
La Crosse
Monroe
Marquette
Green Lake
Fond du Lac
Juneau
Sheboygan
Vernon
Sauk
Columbia
Dodge
Ozaukee
Richland
Washington
Crawford
Dane
Jefferson
Waukesha
Iowa
Milw.
Grant
Racine
Lafayette
Green
Rock
Walworth
Kenosha

CURRENT REVIEW TEAMS:

- CHILD DEATH REVIEW TEAMS
- FETAL INFANT MORTALITY REVIEW TEAMS
- OVERDOSE FATALITY REVIEW TEAMS
- SUICIDE REVIEW TEAMS

Fatality review efforts are supported through Wisconsin Department of Health Services, Wisconsin Department of Justice, and Wisconsin Partnership Program at the Medical College of Wisconsin.