We need to end the paper trail

Why all physicians need to use the state’s electronic system for registering births and deaths.

BY MOLLY MULCAHY CRAWFORD

Every day, more than 300 births, deaths and fetal deaths occur in Minnesota. Physicians play a critical role in documenting these vital events quickly and precisely. Records of these events contain demographic and legal information, and important health and medical information as determined by a physician. This information is used to monitor mortality trends and identify public health concerns that need to be addressed.

Registering births and deaths

Registering a birth with the state is straightforward. One reason is that nearly 99 percent of the 69,000 births that occur in Minnesota each year take place in hospital birthing centers, where systems are in place for gathering and reporting such information.

Physicians have an indirect role in birth registration, as they are responsible for maintaining the mother and child’s medical record. In almost all cases, a designated representative from the hospital (usually a health unit coordinator or a member of the medical records staff) manually enters information from those records into the Minnesota Registration and Certification (MR&C) system, the state’s electronic vital records system. (Currently, electronic health record systems in hospitals and clinics are unable to exchange information with the state’s vital records system.) Some of the information they enter includes the mother’s hepatitis B status, abnormal conditions and congenital anomalies in the newborn, breast-feeding status and maternal morbidity. According to law, a birth, including the required medical information, must be registered with the state within five days.

Registering a death is more complicated. Unlike birth records, death records have two parts. One deals with facts, such as demographic and legal information about the decedent. The other delineates the cause of death and includes relevant medical information. Although a death certificate can be issued with only the facts, both parts are required for a death record to be complete, and both parts are often needed to settle an estate.

Funeral establishments record the facts of a death, and Minnesota law requires that this information be filed with the state within five days of the event.

State law requires medical certifiers, including treating physicians, coroners and medical examiners, to document the cause of death and answer questions about it, including whether an autopsy was performed, the manner of death (natural, suicide, homicide, accidental), whether the decedent was pregnant at the time of death, whether tobacco use contributed to the death and more (Minnesota Rule 4601.1800).

There is no statutory deadline for medical certifiers to register the cause of death. According to data from the state Office of Vital Records, the cause of death was provided within three days for more than half of deaths registered between January 1 and October 31, 2015 (Figure). It was provided more than 10 days after death in 19 percent of cases, often because the record was referred to a medical examiner or coroner or because the physician was waiting for toxicology findings or autopsy results.

**FIGURE**

Length of time after death during which medical information was filed by physicians in Minnesota, January 1 – October 31, 2015.

N = 33,775 deaths. Source: Minnesota Office of Vital Records
More than half of the 41,500 people who die each year in Minnesota are cremated. State law requires a body to be preserved if final disposition will take place more than 72 hours after death. To save costs, families often want cremation to take place within that period. Because Minnesota law requires that the cause of death be known and authorizations be obtained before final disposition, the onus is on the physician to file the necessary information about the cause of death in a timely manner. As more people choose cremation, prompt filing of the medical information about the cause of death will become even more important.

The paper problem
All births and deaths are registered electronically through the MR&C system. This system is used by all hospital birth registrars, funeral establishments, medical examiners and coroners, and issuance offices. Yet, only 81 percent of the records filed by physicians are done so electronically. Further, of the records that come to the Office of Vital Records for manual entry of cause of death information, 27 percent come from physicians who are signed up to use the MR&C system, but send paper. This perpetuation of paper is a problem for everyone involved in vital records activities.

If a physician doesn’t use the MR&C system or if they use it but don’t tend to emails notifying them that there is a death record needing their attention or check their MR&C work queue, it’s up to the funeral establishment to make sure they submit the necessary information. More often than not, funeral staff end up faxing the physician a worksheet to use to complete the cause of death. Sometimes the physician will fax that to the state, only to get an email notification from the MR&C system telling them to provide the cause of death electronically. This can result in confusion and extra work for the funeral staff and the physician.

Continuing to provide cause-of-death information on paper also leaves room for error and can result in different reasons being recorded on the disposition documentation and the death record. For example, functionality within the MR&C alerts physicians when data they provide seem unlikely, such as uterine cancer being the cause of death of a male or natural death being categorized as an overdose. These scenarios can go unchecked if the information is entered manually.

One way to maximize the use of the MR&C system is for physicians to designate a representative who can enter data on their behalf. Practices whose physicians want their partners to be able to register cause-of-death information in their absence were among the first to do this. Now, some large health systems including Mayo Clinic and Essentia Health have staff who act as death registrars and shepherd records through completion within their facilities. Internally, physicians provide the cause of death information to their designees who then document the information and assure that complete and accurate health and medical data are filed without delay.

In fact, of the death records that have cause of death filed directly into the MR&C system, only 25 percent are filed by physicians who log in with their user account and password. The other 75 percent are completed by their designated staff. Physicians need to work with the Office of Vital Records to appoint a designee to submit cause-of-death information on their behalf.

The importance of electronic data
Registering deaths electronically has public health benefits. Because of the improved timeliness for filing death records when people use the MR&C system, Minnesota now sends daily files to the Centers for Disease Control and Prevention’s National Center for Health Statistics (NCHS). The NCHS automatically provides numerical codes from the International Classification of Diseases, 10 Revision (ICD-10) and returns the files to the Office of Vital Records. The quick turnaround allows the Minnesota Department of Health to share nearly real-time death data unlike ever before.

Local public health agencies are now using this information to conduct surveillance and plan prevention activities. Having real-time death data allows them to respond to emerging issues (eg, drug overdose deaths) in a more timely manner. It also helps them address persistent public health concerns such as traffic fatalities, infant mortality and sudden, unexpected infant deaths. In addition, the City of Minneapolis is incorporating 2014 death data into the Big Cities Health Inventory, a project designed to illustrate the major health issues that affect urban communities. The Metro Public Health Analysts Network, which consists of nine city and county public health agencies in the Minneapolis/St. Paul metro area, is exploring opportunities to use this data to conduct surveillance around 18 mortality indicators.

Less paper, greater benefit
Information about births, deaths and fetal deaths is important to families, public health agencies, health care organizations that monitor performance and conduct quality assurance activities, life insurance companies, and other entities. Physicians’ commitment to recording health and medical information related to vital events is crucial to the success of the state’s vital record system. With their voluntary compliance, we can work smarter and faster and with fewer resources, informing public health, serving families and improving lives one record at a time. MM

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For more information about physician responsibilities and requirements when registering a death or to register a designee to submit medical data, contact the Office of Vital Records at 651-201-5993, 888-692-2733 or Health.MRCAdmin@state.mn.us. The Minnesota Department of Health also maintains information on its website specifically for medical certifiers at www.health.state.mn.us/divs/chs/osr/physician-me/.