SUPPORTING STATEMENT FOR
OMB INFORMATION COLLECTION REQUEST

OMB# 0920-0607

Part A

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The National Violent Death Reporting System

Supported by:

Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control
Division of Violence Prevention

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A. Justification

1. Circumstances Making the Collection of Information Necessary

This is a **revision** request for the currently approved National Violent Death Reporting System (NVDRS) - OMB# 0920-0607, expiration date 12/31/2015. The coding manual has been updated to reflect improved guidance to system users for how to code information that has to be entered into the system. The improved coding guidance in the manual helps to ensure data is consistently entered across users. The revision includes updated coding guidance based on questions submitted to CDC staff by data abstractors and clarifications to guidance on data elements that CDC staff have observed to present challenges to abstractors.

Violence is a major public health problem. The World Health Organization has estimated that 815,000 suicides and 520,000 homicides occurred in the year 2000 worldwide. Violence against others or oneself is a major public health problem in the United States, taking 50,000 lives each year. It is a particular problem for the young: suicide was second and homicide was third among leading causes of death for Americans 1-34 years of age in 2010.

Given the importance of the problem, it is noteworthy that no national surveillance system for violence exists in the United States. In contrast, the federal government has supported extensive data collection efforts for the past three decades to record information about other leading causes of death. For example, the National Highway Traffic Safety Administration has recorded the critical details of fatal motor vehicle crashes, which result in about 40,000 deaths among U.S. residents annually. That system, called the Fatality Analysis Reporting System (FARS), has existed since 1975. The result of this investment has been a better understanding of the risk factors for motor vehicle deaths, information that has helped to target safety improvements that have led to a significant decline in motor vehicle fatalities since the 1970s. The federal government, through the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program, has also funded national surveillance for cancer, which is the fourth leading cause of death in younger Americans aged 1-34 years. SEER has been operating since 1973 and has been a key component of national cancer control efforts.

Aware of the longstanding gap in information about violence, public health leaders and others have been pressing the need for a national surveillance system for violent deaths since 1989. In 1999, the Institute of Medicine recommended that CDC develop a fatal intentional injury surveillance system modeled after FARS. That same year, six private foundations pooled their funds to demonstrate that data collection about violent deaths was feasible and useful. They established the National Violent Injury Statistics System (NVISS). NVISS has been administered by the Harvard Injury Control Research Center and includes 12 participating universities, health departments, and medical centers.

In 2000, dozens of medical associations, suicide prevention groups, child protection advocates, and family violence prevention organizations joined a coalition whose purpose was to secure federal funding to extend NVISS-like surveillance nationwide. Congress approved $1.5 million in funding to start the new system, called the National Violent Death Reporting System (NVDRS), in fiscal year 2002.

CDC received initial OMB approval in November 2004 and renewals in January 2007, November 2009, September 2012, and June 2013.

This and similar programs are authorized under section 301 (a) [42 U.S.C. 241(a)] of the Public Health Service Act and section 391 (a) [42 U.S.C. 280(b)] of the Public Service Health Act, as amended (See attachments 1).

1.1 Privacy Impact Assessment

i. Overview of the Data Collection System

This surveillance system is coordinated and funded at the federal level but is dependent on separate data collection efforts in each state managed by the state health departments or their bona fide agent. The system has recently transitioned from a distributed software system with data entry housed in each state health department to a web-based data entry system that uses a streamlined coding system to facilitate data abstraction efficiency.

Access to the web system is provided to each state by CDC. The data collection interface includes internal validation checks and other quality control measures. State project personnel are provided coding training to help increase data quality. Data are continuously transmitted via the web to CDC-based server.

NCIPC is conducting several activities to facilitate high-quality implementation of NVDRS in newly funded states and to maintain data quality in all participating NVDRS states: (1) Provision of scientific and programmatic technical assistance on all aspects of NVDRS via monthly conference calls with all states, and monthly technical assistance calls with each individual new state, (2) An upcoming national meeting (reverse site visit) December 2-4, 2014 that will bring together all NVDRS states, and vital statistics, law enforcement, coroner/medical examiner representatives, (3) Training at the reverse site visit regarding all operations of the web-based reporting platform (e.g., data entry into the system), (4) Training at the reverse site visit regarding all NVDRS case definitions, source data, standardized coding and abstraction of information, and writing of incident narratives, (5) Development of E-learning modules that will be used by states to supplement in-person trainings, (6) Periodic informational webinars in which all NVDRS states are invited to participate.

ii. Items of Information to be Collected

To fully characterize the incidents, states collect information about each incident from three data sources: death certificates, Coroner/Medical Examiner records, and law enforcement records,

including crime labs. Most states find it easiest to begin data collection with death certificates because the state health department itself collects death certificates. Over 250 data elements are collected on each incident from these four principal sources. The record for an incident includes information about all the victims and suspects in each incident and their relationships. All personal identifying information is stripped from the data before it leaves the states.

2. Purpose and Use of Information Collection

The purpose of the program is to continue establishing and maintaining state violent death information collection systems that form the basis of NVDRS. A violent death is defined as a death due to suicide, homicide, an event of undetermined intent, legal intervention or unintentional firearm injury. The purpose of NVDRS is to generate public health surveillance information at the national, state, and local levels that is more detailed, useful, and timely than is currently available. This information will help develop, inform, and evaluate violence prevention strategies at both state and national levels. Without this information, violence prevention efforts are often based on anecdotal, nonscientific information. This program addresses the Healthy People 2020 focus area of Injury and Violence Prevention **.**

We need to continue this surveillance system to allow our knowledge regarding events that surround the occurrence of a violent death to increase. States that currently collect this data are just beginning to experience the value of such a system. Violent death data gathered by states is being used to guide the development of reports, modify annual prevention plans, and inform prevention strategies. The system is helping states to collaborate with data partners that have not existed in the past.

The president has submitted plans to fund all 50 U.S. states, the District of Columbia, and possibly the U.S. territories to participate in NVDRS. This expansion would help all states experience the benefits of the system, and would lead to the availability of nationally representative information about violence that could be used in the ways listed above. Funding for the expansion of NVDRS was approved, and enabled 13 new states to be added to the system in September, 2014. Additional funding for expansion to the remaining jurisdictions has been proposed in the 2016 budget.

Publications that have used NVDRS data both at the state and national level include: *MMWR*s – Homicides and Suicides – NVDRS 2003; Homicides and Suicides – NVDRS 2003-2004; Surveillance Summaries – Surveillance for Violent Deaths - NVDRS April 2008, March 2009, May 2010, August 2011, and September 2012; Gang Homicides in Five U.S. Cities 2003-2008; State annual reports for SC, OR, VA, NJ, WI, OK, MA, AK, UT and MD; a Supplement to the journal *Injury Prevention* dedicated to NVDRS – December 2006; *Deaths from Violence: A Look at 17 States* – December 2008; and over 60 peer-reviewed publications by numerous researchers in the field of violence prevention.

2.1 Privacy Impact Assessment

States treat their data in a secure manner and protect it with all applicable state laws for the protection of public health surveillance information. Data is de-identified, personal identifiers are not included in the information transmitted from states to CDC, and only de-identified data is available for analysis and reporting. For further information, see section 10.

The proposed data collection will have little or no effect on the respondent's privacy.

3. Use of Improved Information Technology and Burden Reduction

The system has recently transitioned from a distributed software system with data entry housed in each state health department to a web-based data entry system that uses a streamlined coding system to facilitate data abstraction efficiency.

Data entry is accomplished in health department offices or in the field in the offices of medical examiners and police departments via a secure internet platform. States have the option of electronically importing death certificate and CME data into the system. The importation function reduces the burden for manual entry and paper copies. Law enforcement and crime laboratory data are manually entered from the paper records into the NVDRS web system. The data collection interface includes internal validation checks and other quality control measures. State project personnel are provided coding training to help increase data quality through a detailed coding manual, online help functions, webinars, and a coding helpdesk. Data are continuously transmitted via the web to CDC-based server.

4. Efforts to Identify Duplication and Use of Similar Information

There is no similar ongoing surveillance system in existence. The National Violent Injury Statistics System was a privately-funded data collection system that was expressly designed as a pilot test for NVDRS. The system ceased to collect data from its twelve local sites in 2004.

No system to date has attempted to combine information on violent deaths from such a variety of sources on such a scale. NVDRS uses information from death certificates, medical examiner/coroner records, law enforcement records (including crime lab information). These individual sources are death-based rather than incident-based and cannot link violent deaths involved in a single incident, such as suicides followed by the homicide of the perpetrator.

5. Impact on Small Businesses or Other Small Entities

This study does not impact small businesses or other small entities. It impacts public agencies such as health departments, police departments, sheriffs' offices, crime labs, and medical examiner/coroner offices, whose records are accessed in the course of data collection. A number of the data items have been flagged as optional items to allow these agencies to reduce the amount of data they collect at their discretion.

6. Consequences of Collecting the Information Less Frequently

A complete census of violent deaths is required to obtain the detail necessary for prevention at the state level. Data collection must be continuous to monitor epidemics of violence and the impact of prevention measures. The new web-based data entry system allows states to see any trends much quicker than previously available, as data are continuously updated and accessible.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the regulation 5 CFR 1320.5

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A. A 60-day Federal Register Notice was published in the Federal Register on February 11, 2014, vol. 79, No. 28, pp. 8188-89(Attachment 2). CDC received two public comments in response to the publication of the 60-day notice. See Attachments 7 and 8.

i. One public comment was from a nonprofit organization dedicated to suicide prevention among lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. Their representative commented on the following topics: (a) Suggested best practices for capturing gender identity and sexual orientation, (b) Altering existing and adding new data elements to be more inclusive of LGBTQ persons. These comments were addressed in a letter thanking the Trevor Project for their feedback, and conveying that the NVDRS team will consider the changes that they recommend.

ii. The other public comment was from the Ann & Robert H. Lurie Chicago Children's hospital. Their representative commented on the following two topics: (1) Their local experiences with the benefits of public health surveillance of violent deaths, via the Illinois Violent Death Reporting System, and (2) Their perspective on the benefits of using electronic death records, as some states have done. These comments were addressed in a letter thanking the Ann & Robert H. Lurie Chicago Children's Hospital for sharing their perspective on violent death surveillance.

B. NCIPC consulted with the following entities regarding this study:

NCIPC consulted with the NVDRS Implementation Work Group, which includes national injury and violence experts regarding the content of the study. Consultation began in 2002. NCIPC maintains a partnership with the national organizations that represent the major data sources used by NVDRS. The organizations include the State and Territorial Injury Prevention Directors' Association (STIPDA), the National Association of Medical Examiners (NAME), the National

Association of Public Health Statistics and Information System (NAPHSIS), the International Association of Police Chiefs (IACP) and the National Violent Injury Statistics System (NVISS).

NCIPC is engaged in an ongoing dialogue with the National Center for Health Statistics (NCHS), Division of Vital Statistics, concerning joint efforts to continue to work toward incremental improvement of timeliness and quality of death certificate data. NCIPC and NCHS have a mutual interest in working jointly with states toward these improvements.

9. Explanation of Any Payment or Gift to Respondents

The CDC funds state health departments or their bona fide agents to participate in NVDRS through cooperative agreements. State health departments have formed interagency agreements with police departments, other law enforcement agencies, medical examiner offices, and the like to share their data. In several states, the health departments have entered into contracts with the data sources to support the clerical effort required to obtain and refile case records for NVDRS abstractors. Deceased victims of violence and the people who killed them are described in the data, but they (or their next of kin) are never contacted in the collection of data.

10. Assurance of Confidentiality Provided to Respondents

This submission has been reviewed by the CIO who determined that the Privacy Act does not apply. Although sensitive information will be collected by state health departments (the respondents), all personally identifying information is stripped from the files before the case-level data is sent to CDC. Only selected staff working in the state NVDRS program will have access to state information.

Some states may abstract information onto worksheets as an intermediate step prior to data entry into a computer. These worksheets contain personal identifiers. They will be stored in locked file cabinets to which only state NVDRS staff will have access. Such worksheets will never be sent from the state to the CDC or to a CDC contractor.

States treat their data in a secure manner and protect it with all applicable state laws for the protection of public health surveillance information.

To ensure that data is secure and anonymity, a number of procedures will be implemented:

- Data is maintained securely throughout the data collection and data processing phases. Data is primarily stored on a secure CDC_based server accessed via a secure web platform. Supplemental data may be stored at the state level in secured computers that reside within state health department firewalls.
- The CDC system does not store personal identifying information such as names, address, SSN, date of birth, etc., .
- NVDRS follows NCHS guidelines on suppression of small sample sizes in data tabulations to prevent the inadvertent identification of an individual through the combination of various demographic characteristics, e.g., a 98 year old man from Pawtucket County in Massachusetts might be readily identifiable.

IRB Approval

This data collection has been determined to be non-research, injury surveillance. An NCIPC Determination has been completed (Attachment 6).

10.1 Privacy Impact Assessment Information

This submission has been reviewed by CIO who determined that the Privacy Act does not apply.

1. Information obtained in this data collection pertains to deceased individuals, therefore **there is no need to provide information pertaining to the voluntary or mandatory nature of the data collection.**
2. Information obtained in this data collection pertains to deceased individuals, therefore there is no need for consent in the collection of data.
3. Information obtained throughout the data collection process will be secured on CDC servers which are protected (using firewalls, etc.
and

4. A system of record has not been created under the Privacy Act.

11. Justification for Sensitive Questions

No sensitive questions are asked directly to individuals involved in violent incidents or their next of kin. Information on sensitive issues, e.g., mental illness and substance abuse, are collected about the deceased victims from the records of public agencies. Such items are not captured about living suspects. Such information is critical for the identification of preventive measures.

12. A. Estimates of Annualized Burden Hours and Costs

The burden was estimated as follows:

We are using our experience with the currently 18 funded states to estimate the annualized burden hours and costs. The number of violent deaths per year in an average state was estimated by dividing the total number of such deaths nationwide (50,000) by 50. The number of hours per death required for the public agencies working with NVDRS states to retrieve and then refile their records was estimated at 0.5 hours per death. Moving forward, we will no longer include state abstractors' time spent abstracting data in our estimates of public burden for NVDRS because state abstractors are funded by CDC to do this work. This significantly reduces the estimated public burden associated with NVDRS.

Estimated Annualized Respondent Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Public Agencies	Retrieving and refile records	58	1000	30/60	29,000
Total					29,000

12. B. Estimated Annualized Respondent Burden Costs:

Public Agencies who retrieve and refile records estimate costs at [500 hours x 58 states x $15/hour] = $435,000. In some cases, state health departments may subcontract with the public agencies or otherwise find a way to defray these costs.

Type of Respondent	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Cost

Public Agencies	58	1000	30/60	29,000	$15	$435,000
Total						$435,000

13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

Respondents will incur no capital or maintenance costs.

14. Annualized Cost to the Government

These costs fall into several categories, listed below:

Contractor phases, tasks, and estimated costs

LABOR	COST
MISO contract for maintenance of the data collection software	$175,000
Contracts and cooperative agreements with national data partners	$50,000
Other Direct Costs	
Subcontractors	$0
Travel and subsistence	$0
Total Estimated Contract Costs	**$225,000**

Government costs

Personnel	Tasks	Avg. cost/yr
Senior Scientist	Program oversight	$105,000
3 Epidemiologist	Technical assistance and data usage	$273,600
3 Public Health Advisors	Programmatic, budgetary, administrative management & oversight	$282,200

Computer Informatics Specialist	Database design	$91,200
Public Health Analyst	Data quality assurance	$80,000
Sub-total		**$832,000**

Total annual contractual and government staff costs are approximately $1,057,000.

This is a multi-year project, with the initial cooperative agreements spanning five years. The total cost over five years for contractual and government staff will be approximately five times the annual cost plus three percent cost of living.

15. Explanation for Program Changes or Adjustments

This surveillance system began collecting data in 2003. This is a revision request for the currently approved National Violent Death Reporting System.
The president has submitted plans to fund all 50 U.S. states, the District of Columbia, and U.S. territories to participate in the National Violent Death Reporting System. The proposed changes will expand the system significantly from the current participation level of 18 U.S. states, to a total of 58 public health agencies, which include the 50 U.S. states, the District of Columbia, and territories to be included in the state-based surveillance system.

16. Plans for Tabulation and Publication and Project Time Schedule

Data aggregated across states will be presented in tabulations of outcomes such as homicide rates and suicide rates by age group. These will be released in CDC publications such as *MMWR* or in other peer-reviewed publications. A web-based query system to allow electronic querying of the information has been developed and available to the public since November 2008.

Time Schedule

Task	Time Period
Preliminary analysis files	9 months after the data year
Final analysis files	21 months after the data year
Restricted Access Data files	21 months after the data year
MMWR	At least one article per year
NVDRS data query system	Updated annually

Initial reports will include crude and age-adjusted rates by state for suicide, homicide, undetermined cause of death, legal intervention, unintentional firearm injury, and terrorism. Sex, race, and age-specific rates is also presented. The percent of different types of violent deaths associated with specific circumstances, eg, a history of substance abuse, will be presented.

In later years, time trends will be shown. No sophisticated statistical techniques will be required to display this surveillance data.

17. Reason(s) Display of OMB Expiration Date Is Inappropriate

The display of the OMB expiration date is not inappropriate

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.