SUPPORTING STATEMENT: *PART A*

The National Violent Death Reporting System

OMB# 0920-0607

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- Goal of the project: This is a revision request. The purpose of this revision is four-fold: 1) implement updates to the web-based system to improve performance, functionality, and accessibility, 2) adding new data elements to the system and minimal revisions to the NVDRS coding manual; 3) modify burden hours to account for the increase in violent deaths that have occurred in the U.S. since 2003; and 4) decrease the number of state health departments to be included in the system from 58 to 56 to align with the number of state health departments NVDRS seeks to fund. The National Violent Death Reporting System (NVDRS), implemented by the Centers for Disease Control (CDC), is a state-based surveillance system developed to monitor the occurrence of violent deaths (i.e., homicide, suicide, undetermined deaths, and unintentional firearm deaths)in the United States (U.S.) by collecting comprehensive, detailed, useful, and timely data from multiple sources (i.e., death certificates, coroner/medical examiner reports, law enforcement reports) into a useable, anonymous database.

- Intended Use of the Resulting Data: Comprehensive surveillance data on violent deaths are needed to describe and characterize such incidents, describe the associated risk factors and circumstances that precipitated the incident, and inform prevention programs, policies, and practices at the local, state, and national levels.

- Methods to be Used to Collect: Each state, District of Columbia, and U.S. territory (referred to hereinafter as "states") is funded to abstract standard data elements from three primary data sources: death certificates, coroner/medical examiner records, and law enforcement records into a web-based data entry system, supplied by CDC.

- The subpopulation to be studied: Individuals who die from a violent death.

- How data will be analyzed: This is an ongoing surveillance system that captures annual violent death counts and circumstances that precipitate each violent incident. CDC aggregates de-identified data from each state into one large national database that is analyzed and released in annual reports and publications. Descriptive analyses such as frequencies and rates will be employed. A restricted access database is available for researchers to request access to NVDRS data for analysis and a web-based query system is open for public use that allows for electronic querying of data.

A. JUSTIFICATION

This is a revision request for the currently approved National Violent Death Reporting System (NVDRS) - OMB# 0920-0607, expiration date 10/31/2017. With this revision, CDC is requesting OMB approval for an additional 3 years to continue data collection

efforts.

Extensions and revisions have been requested in the past; CDC received initial OMB approval in November 2004 and renewals in January 2007, November 2009, September 2012, June 2013, and October, 2014.

The purpose of this revision is four-fold: 1) implement updates to the web-based system to improve performance, functionality, and accessibility, 2) adding new data elements to the system and minimal revisions to the NVDRS coding manual; 3) modify burden hours to account for the increase in violent deaths that have occurred in the U.S. since 2003; and 4) decrease the number of state health departments to be included in the system from 58 to 56 to align with the number of state health departments NVDRS seeks to fund.

1. Circumstances Making the Collection of Information Necessary

Background
Violence is a major public health problem. The World Health Organization has estimated that 804,000 suicides and 475,000 homicides occurred in the year 2012 worldwide[i,ii]. Violence against others or oneself is a major public health problem in the United States, and is a particular problem for the young: suicide and homicide was among the top 4 leading causes of death for Americans 10-34 and 1-34 years of age in 2015, respectively[iii]. A key to preventing these violent deaths is to understand and target their circumstances (the "who", "when", "where", and "how").

Given the magnitude of the problem, it is noteworthy that no national surveillance system for violent deaths existed in the U.S. until the NVDRS was developed. In contrast, the federal government supported extensive data collection efforts for several 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[iv].

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[v]. 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 was administered by the Harvard Injury Control Research Center and included 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. In fiscal year 2002, the first appropriation from Congress was approved for $1.5 million in funding to start the new system, called the National Violent Death Reporting System (NVDRS)[vi].

NVDRS 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. NVDRS collects data on violent death, defined as a death resulting from the intentional use of physical force or power (e.g., threats or intimidation) against oneself, another person, or against a group or community. This includes all homicides, suicides, and deaths occurring when law enforcement exerts deadly force in the line of duty. In addition, NVDRS states are required to collect information about unintentional firearm injury deaths (i.e., incidents in which the person causing the injury did not intend to discharge the firearm) and on deaths where the intent cannot be determined ("undetermined deaths") but where there is evidence that force was used. Although these deaths are not considered violent deaths by the above definition, information is collected on these types of death because some of these deaths may have been violent. The collection of this data comes from three primary data sources: death certificates, coroner or medical examiner reports (some states have coroner systems while others have medical examiner or combined systems), and law enforcement records. Most states find it easiest to begin data collection with death certificates because the state health department itself collects death certificates. An average of 250 data elements are collected on each incident.

This program is 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 (Att. 1).

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. 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. It is not enough to know the magnitude of violence. It is also important to understand what factors protect people or put them at risk for experiencing violence. The collection of such information will help identify where prevention efforts need to be focused. 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.

Publications that have used NVDRS data both at the state and national level include:

Morbidity and Mortality Weekly Reports (MMWRs) [xiv]–

- Suicide Rates by Occupation Group─ 17 States, 2012
- Gang Homicides ─Five U.S. Cities, 2003-2008
- Homicides─ United States, 1999-2007
- Alcohol and Suicide Among Racial/Ethnic Populations ─ 17 States, 2005-2006
- Toxicology Testing and Results for Suicide Victims ─13 States, 2004
- Homicide and Suicides─ NVDRS, United States, 2003-2004
- Homicides and Suicide Rates – NVDRS, Six States, 2003
- Surveillance Summaries – *Surveillance for Violent Deaths – NVDRS*, published Aug 2016, Jul 2016, Jan 2014, Sept 2012, Aug 2011, May 2010, Mar 2009, Apr 2008

State annual reports[xv] –

- AK, CO, CT, GA, KY, MD, MA, NJ, NM, NC, OH, OK, OR, RI, SC, UT, VA, WI

Supplements– Two scientific journal supplements dedicated to NVDRS:

- *American Journal of Preventive Medicine ─ National Violent Death Reporting System: Analyses and Commentary*, November 2016
- *Injury Prevention ─ Deaths from Violence: A Look at 17 States* – December 2008

Peer-reviewed publications – Over 80 peer-reviewed reports published between 2003 and 2016 by numerous researchers in the field of violence prevention, including most recently:

- Barber, C et al., (2016). Homicides by Police: Comparing Counts From the National Violent Death Reporting System, Vital Statistics and Supplementary Homicide Reports *American Journal of Public Health, 106(5).* doi: 10.2105/AJPH.2016.303074
- Schiff, et al., (2015). Acute and Chronic Risk Preceding Suicidal Crises Among Middle-Aged Men Without Known Mental Health and/or Substance Abuse Problems: An Exploratory Mixed-Methods Analysis. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. http://dx.doi.org/10.1027/0227-5910/a000329.
- Fowler et al., (2015). Increase in Suicides Associated with Home Eviction and Foreclosure During the US Housing Crisis: Findings from 16 National Violent Death Reporting System States, 2005-2010. *Am Journal of Public Health, 105:311–316.* doi:10.2105/AJPH.2014.301945.

3. Use of Improved Information Technology and Burden Reduction

The system transitioned in 2013 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 coroners, medical examiners and law enforcement via a secure internet platform. States have the option of electronically importing death certificate and coroner/medical examiner (CME) data into the system. The importation function reduces the burden for manual entry and paper copies. Law enforcement 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 (Att. 7), online help functions, webinars, monthly coding workgroup calls, and the NVDRS Help Desk. Data are transmitted real time via the web to CDC-based server.

4. Efforts to Identify Duplication and Use of Similar Information

Continuous review of data collected and disseminated by private and public agencies indicates that 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.

- Death Certificates from the National Vital Statistics System records mainly counts deaths, including homicide and suicide. The system only provides decedent demographics, incident location, and method of death and does not provide information on risk factors for violent deaths, such as mental health and criminal history.

- Local and Federal criminal justice agencies such as the Federal Bureau of Investigations provide slightly more information about homicides, but they do not routinely collect standardized information about suicides, which occur more frequently than homicides. The FBI's Supplemental Homicide Report (SHR) collects basic information about victim-suspect relationship and circumstances related to the homicide, however SHR does not link violent deaths that are part of one incident such as homicides-suicides. SHR is also a voluntary system in which very few departments nationwide participate. The FBI's National Incident Based Reporting System (NIBRS) provides slightly more information than SHR but covers less of the country that SHR. NIBRS also only provides data on homicides.

- Other morbidity and mortality data systems only collect information on select outcomes in select populations. The Department of Defense Suicide Event Report (DODSER) collects data on suicides and suicidal behaviors among US military personnel. The Department of Justice's Data collection systems such as the Deaths in Custody Reporting Program and the National Corrections Reporting Program all have the general purpose to report on health conditions and outcomes of persons in various correctional institutions or under the jurisdiction of law enforcement agencies. The National Intimate Partner and Sexual Violence Survey

(NISVS) collects self-report data specifically on sexual violence, stalking, and intimate partner violence.

- CDC's State Unintentional Drug Overdose Reporting System (SUDORS) is a state-based surveillance system developed to provide more timely data on fatal and nonfatal opioid overdoses and in-depth information on risk factors. NVDRS does not collect information on unintentional drug overdoses. Although SUDORS added overdose-specific variables fields to the NVDRS web-based system as an optional module, the collection of this data is not part of NVDRS.

Furthermore, no system to date has attempted to combine information on violent deaths from such a variety of sources on such a scale. Prior to NVDRS' launch, information on violent deaths (i.e., homicides, suicides, and legal intervention, unintentional firearm) was fragmented across a variety of databases and data sources and collected in a non-standardized manner. NVDRS solved this problem by allowing participating states to combine data from law enforcement reports, coroner/medical examiner reports, death certificates, and crime laboratories into a useable anonymous surveillance database. NVDRS provides a complete picture by 1) linking multiple deaths (e.g., multiple homicides, suicide pacts, and cases of homicide followed by the suicide of the suspect) into a single record, and 2) collecting information on who dies violently, where victims are killed, and when and how they are killed. NVDRS also collects information on the suspect and the relationship of the victim to the suspect to better characterize homicides. Finally, NVDRS is the first system to collect brief narratives that provide what factors contribute or precipitate the death, including victim-suspect relationship, mental health history, and personal stressors.

Currently, in efforts to comply with OMB requirements, NCIPC/NVDRS is engaged in ongoing dialogue with the National Center for Health Statistics (NCHS) concerning joint efforts to continue to work toward incremental improvement of timeliness and quality of death certificate data. Scientists from NCHS have presented updates on the National Vital Statistics System (NVSS) at NVDRS Reverse Site Visits, in December 2014, May 2016, December 2016, and May 2017. During these NVDRS reverse site visits, NVDRS management staff also interfaced with NCHS for discussions about NVDRS. NVDRS will continue to invite NCHS to interface with NVDRS states to discuss any recent developments or issues with obtaining timely and accurate death certificate records. In May 2015, NVDRS staff met with NCHS and the National Association of Public Health Statistics and Information System (NAPHSIS) to discuss timeliness and quality of mortality data. In October 2015, NVDRS management staff met with NCHS management to discuss the NVSS and NVDRS and opportunities for collaboration. NVDRS management staff also participates in monthly conference calls organized by NCHS regarding the electronic death registration system.

NCIPC/NVDRS has also been in discussions with NCHS about data intergration. In December 2016, NCHS briefed the CDC NCIPC Director on a project to integrate data from CME case management systems with other related public health reporting systems.

In November 2017, NVDRS will take part in an initial conceptual discussion with NCHS about their plans to implement electronic interoperability of CME case management systems and public health reporting systems, such as electronic death registration systems and death reporting systems (e.g. NVDRS, SUDORS). Further engagement between NCHS and NVDRS is being planned to learn how NVDRS can share knowledge with NCHS. The current goals of this project for NCHS are to: 1) identify the data elements that that CME offices are most frequently asked to report to multiple stakeholders and 2) begin to develop/test more modern, application programming interfaces (API)-driven approaches to exchanging common data elements with public health and public safety partners. NVDRS will continue to collaborate with NCHS, alongside SUDORS, sharing information about the NVDRS' data collection process and how NCHS can work with NVDRS states and their local partners on solutions that will help reduce the burden on CME offices that report data to NCHS. It is hoped that this project will help optimize investments and provide mutual benefit to NVDRS and NCHS. NVDRS has established regular meetings with colleagues working on SUDORS. We are also actively communicating with SUDORS and NCHS colleagues about these funded projects. We are interested in learning more about opportunities to help ensure efforts are aligned.

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

Continual public health surveillance 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, target violence prevention efforts, and to evaluate the impact of prevention programs. 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 data collection complies fully with the guidelines in 5 CFR 1320.5.

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

A. Federal Register Notice

A 60-day Federal Register Notice was published in the Federal Register on September 6, 2016, vol. 81, No. 172, pp. 61217-18 (Att. 2). CDC received one anonymous non-substantive comment and two substantive comments (Att. 3).

i. One public comment was from a consultant and a non-profit organization

dedicated to suicide prevention among lesbian, gay bisexual, transgendered, and questioning (LGBTQ) youth. Their comments were about NVDRS' collection of sexual orientation and gender identity data and suggested best practices for capturing these data. These comments were addressed in a letter thanking them for sharing their feedback and perspective and how NVDRS will consider their recommendations in future modifications of the system.

ii. The second public comment was from a private citizen (no organization affiliation noted) who provided a comment on the need for CDC to collaborate with the U.S. Department of Justice on their newly developed database on police use of deadly force. These comments were addressed in a letter thanking him for his perspective and briefly discussed NVDRS' current efforts in addressing this topic.

B. Efforts to Consult Outside the Agency

NCIPC maintains a partnership with the national organizations that represent the major data sources used by NVDRS. The organizations include the National Association of Medical Examiners (NAME), the National Association of Public Health Statistics and Information System (NAPHSIS), and the International Association of Police Chiefs (IACP). NVDRS also has close partnerships with Safe States Alliance, the American Public Health Association (APHA), Council of State and Territorial Epidemiologists (CSTE), and the American College of Preventive Medicine (ACOPM), all of which comprise national injury and violence experts who are able to provide feedback regarding the content of this system. In 2017, NVDRS participated in a meeting with APHA and stakeholders from a number of agencies. With this meeting, future goals include strategizing ways to increase awareness of NVDRS with law enforcement.

9. Explanation of Any Payment or Gift to Respondents

Public agencies (i.e., the respondents) will not receive payments or gifts for providing information. 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/coroner offices to share their data. In several states, the state health departments have entered into contracts with the data providers 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. Protection of the Privacy and Confidentiality of Information Provided by Respondents

NCIPC's Information Systems Security Office has determined that the Privacy Act does not apply for NVDRS. The Privacy Impact Assessment (PIA) is attached (Att. 4).

Sensitive information is collected by state health departments from the vital statistics (death certificates), coroner/medical examiner records and law enforcement records, however 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. Thus, data collection will have little or no effect on the respondent's privacy. States treat their data in a secure manner and protect it with all applicable state laws for the protection of public health surveillance information.

CDC and state health departments will conduct analyses of the data and share aggregate results with the public through a public use dataset.

To ensure privacy 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.

11. Institutional Review Board (IRB) and Justification for Sensitive Questions

IRB Approval

The CDC National Center for Injury Prevention and Control's OMB and human subject's liaison has determined that IRB approval is not needed for this non-research surveillance work. No personal information will be collected and human participants will not be used (Att. 5)

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 information is critical for the identification of preventive measures.

12. A. Estimates of Annualized Burden Hours and Costs

There are no standard paper data collection forms to be used by states because states will be abstracting information from electronic or paper vital statistics, coroner/medical examiner and law enforcement records into the CDC web-based data system (Att. 6). We are using our over 10 years of experience working with states to estimate the annualized burden hours and costs.

The burden was estimated as follows:

- In previous OMB packages, the burden was calculated for 58 states (respondents) reporting 58,000 violent deaths which averages to 1,000 deaths per state. Burden estimates will now include projected hours for 56 states.

- The number of violent deaths per year in an average state we estimated by dividing the total number of deaths nationwide (≈ 68,500) by 56. In 2015, 67,431 deaths were classified as either homicides, legal intervention, suicides, or undetermined deaths[iii]. There are no national estimates of unintentional firearm deaths, however, data from 17 NVDRS states showed that these deaths accounted for less than 1% of violent deaths recorded in these states in 2013[xvi].

- 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.

The total estimated annualized burden hours is summarized in Table A.12-A

Table A.12-An 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 (Att. 6)	56	1,223	30/60	34,250
Total					34,250

B. Estimated Annualized Respondent Burden Costs:

There are no direct costs to public agencies; the data is routinely available in each reporting office as a by-product of their on-going activities. The staff who are retrieving records will vary across agencies. Therefore, we used the average hourly salary of office and administrative support staff of $17.91[xvii]. Public agencies who retrieve and refile records estimate costs at [34,250 burden hours x $17.91/hour] = $613,417. In some cases, state health departments may subcontract with the public agencies or otherwise find a way to defray these costs.

Table A.12-B. Estimated Annualized Burden 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	56	1,223	30/60	34,250	$17.91	$613,417
Total						$613,417

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	$300,000
Contracts and cooperative agreements with national data partners	$315,000
Other Direct Costs	
Subcontractors	$0
Travel and subsistence	$0
Total Estimated Contract Costs	**$615,000**

Government costs

Personnel	**Tasks**	**Avg. cost/yr**
Senior Scientist	Program oversight	$110,000
5 Epidemiologists	Technical assistance and data usage	$465,000
5 Public Health	Programmatic, budgetary,	$475,000

Advisors	administrative management & oversight	
Computer Informatics Specialist	Database design	$100,000
Computer Scientist	Data quality assurance	$95,000
Statistician	Data analysis	$92,000
Sub-total		**$1,337,000**

Total annual contractual and government staff costs are approximately $1,952,000.

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 two percent (2%) cost of living.

15. Explanation for Program Changes or Adjustments

There are minimal changes to the coding manual (Att. 7) in this revision; however, there have been updates to the web-based system to improve performance, functionality, and accessibility for funded states. Recent changes include updates to question wording and response choices of a few variables. Additionally, the system added categories to suspect-related data elements (Att 8) that were previously captured in the narrative field, including whether a suspect(s) was suspected of being under the influence of alcohol or other substances at the time of the incident, had a history of developmental disability, had recent contact with law enforcement, and was recently released from an institution. These changes do not increase burden hours or costs to public agencies. States will request the same records from the same public agencies that they are currently requesting. The added overdose module to the system are not required variables for NVDRS data collection, and thus does not increase burden or costs the public agencies.

After review of most recent published data, there has been a significant increase in violent deaths across the U.S. According to CDC's WISQARS, between 2003 (the inception of this surveillance system) and 2015, violent deaths (i.e., homicides, suicides and undetermined deaths) have increased by 23%. Consequently, this increase impacts the number of responses per respondent, increasing it from 1,000 (as written in previous OMB requests) to 1,223 and increases the total burden hours for public agencies to retrieve these records from 29,500 to 34,250.

NVDRS has always had the goal to be a nationally representative surveillance system, operating in all 50 states, District of Columbia and U.S. territories. Given this, the number of respondents have included all areas although funding has only allowed for a proportion of states to participate in the system. In previous OMB packages, we calculated the number of respondents to be 58, which included 50 states, District of Columbia, 5 U.S. territory health departments (Puerto Rico, Guam, American Samoa,

and the Commonwealth of the Northern Mariana Islands (Northern Marianas, U.S. Virgin Islands) plus large local health departments that may function as its own self-governing entity separate from the state health department (e.g., New York City, Los Angeles County). Our request is to reduce the number of respondents to 56, excluding large local health departments as an independent respondent in NVDRS.

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 the Morbidity and Mortality Weekly Report *(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**
Final analysis files	19 months after the data year
Restricted Access Data files	19 months after the data year
MMWR	At least one article per year
NVDRS data query system	Updated annually

Annual reports will include crude and age-adjusted rates 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. Time trends will also be shown. No sophisticated statistical techniques (e.g. weighting) will be required to display this surveillance data.

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

There are no standard paper data collection forms to be used by states. Data is entered into the web-based system either manually or electronically by importing death certificate and/or coroner/medical examiner (CME) data into the system (Att. 6). The OMB expiration date can be displayed on the opening screen of the software if required.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

This collection of information involves no exception to the Certification for Paperwork Reduction Act Submissions.

[i] World Health Organization. Global Status Report on Violence Prevention. Geneva: WHO Press; 2014. Retrieved from

http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/

[ii]World Health Organization. Preventing Suicide: A Global Imperative. Geneva: WHO Press; 2014. Retrieved from www.who.int/mental_health/suicide-prevention/world_report_2014/en

[iii]CDC. Web-based Injury Statistics Query and Reporting System (WISQARS). Atlanta, GA: CDC; 2015. http://www.cdc.gov/injury/wisqars/index.html

[iv] U.S. Department of Transportation. Report to Congress NHTSA's Crash Data Programs. Washington, DC; 2010. Retrieved from https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/811337.

[v] Bonnie RJ, Fulco CE, Liverman CT, eds. Reducing the burden of injury: advancing prevention and treatment. Institute of Medicine. Washington DC: National Academies Press, 1999. Retrieved from http://www.nap.edu/openbook.php?record_id=6321.

[vi]Blair JM, Fowler KA, Jack SPD, Crosby AE. The National Violent Death Reporting System: overview and future directions. Inj Prev 2016;22(Suppl 1):i6–11.

[vii]. Safe States Alliance. NVDRS: stories from the frontlines of violent death surveillance; 2015. http://c.ymcdn.com/sites/www.safestates.org/resource/resmgr/NVDRS/NVDRS_Stories_-_2015.pdf

[viii]NVDRS: Stories from the Frontlines of Violent Death Surveillance (2013). Atlanta (GA): Safe States Alliance. Available at http://www.safestates.org/?NVDRSStories.

[ix]Spencer-Thomas S, Hindman J, Conrad J. ManTherapy™: an innovative approach to suicide prevention for working aged men [White paper]; 2012. http://mantherapy.org/pdf/ManTherapy.pdf

[x]Colorado Department of Public Health and Environment. Office of Suicide Prevention annual report: suicide prevention in Colorado 2014–2015; 2015. https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_OSP-2014-2015-Legislative-Report.pdf

[xi]Office of the Surgeon General; National Alliance for Suicide Prevention. 2012 national strategy for suicide prevention: goals and objectives for action. Washington, DC: US Department of Health and Human Services; 2012.

[xii] World Health Organization. Preventing Suicide: A Global Imperative. Geneva: WHO Press; 2014. Retrieved from www.who.int/mental_health/suicide-prevention/world_report_2014/en

[xiii] US Department of Health and Human Services. Healthy People 2020. Washington, DC: CDC; 2013. https://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx

[xiv] Reports can be found here https://www.cdc.gov/violenceprevention/nvdrs/publications.html

[xv] Webpage address for each state health department, where the NVDRS reports can be found are located here https://www.cdc.gov/violenceprevention/nvdrs/stateprofiles.html

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