

***SUPPORTING STATEMENT: PART B***

**The National Violent Death Reporting System**

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## **B. Collection of Information Employing Statistical Methods**

### **1. Respondent Universe and Sampling Methods**

The respondent universe comprises the 56 jurisdictions: 50 states, the District of Columbia, and U.S. territory health departments. NVDRS funded participants collect data on all violent deaths occurring in their jurisdiction. The exception is for large states that have more than 2,000 violent deaths occurring per year—these states have the option to collect data in selected counties/ targeted areas that represent at least 40% of all violent deaths occurring within their jurisdiction, and some may achieve statewide coverage. The goal of NVDRS is to collect state-wide data in all funded entities. No sampling methods will be employed.

### **2. Procedures for the Collection of Information**

The 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 agents. NVDRS collects data on violent deaths, 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, unintentional firearm deaths, deaths of undetermined intent, deaths due to legal intervention (excluding executions). NVDRS cases are identified using the International Classification of Diseases, Tenth Revision (ICD-10) codes, or by using the manner of death assigned by the coroner, medical examiner or law enforcement. In accordance with the system's design principles, the data system is incident-based (violent deaths that are related and occur within 24 hours of each other such as multiple homicides) rather than victim-based. The record for an incident includes information about all the victims and suspects in each incident and their relationships.

To fully characterize incidents, NVDRS recipients collect information about each incident from three primary data sources: death certificates, coroner/medical examiner (CME) records, 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. Over 250 data elements are collected on each incident from these three principal sources, however the system has the capability to collect >600 variables for each death depending upon the content of the source documents and the various incident scenarios. See attached list of NVDRS data elements (Att. 9).

Data collection can be done either by manual abstraction from the primary data sources or by electronic transfer or importation, whichever proves to be the more timely way to acquire the necessary information. Death certificate information is available to most health department and entered into the system within 4 months. Law enforcement and CME data are most often available within 16 months of the occurrence of the death.

Data entry is accomplished at each state health department. The data are entered into a web-based system via a secure internet platform. The web-system interface includes internal validation checks and other quality control measures. Each state is provided a coding training to help increase data quality. Data are continuously transmitted via the

web to a CDC-based server.

Violent death surveillance faces challenges that are in some ways unique among public health surveillance systems. First, there is a fundamental difficulty with the use of different case definitions: the same death may be called unintentional on a law enforcement record, homicide by a medical examiner, and undetermined on the death certificate. Different case definitions may be used even within one professional community, such as that of medical examiners<sup>i</sup>. To address this problem, NVDRS abstractors are trained to use standard conceptual definitions for different types of violent death.

There are also more legal issues associated with violent deaths than with deaths from natural causes. The integrity of a death investigation is important, and access to law enforcement and medical examiner/coroner files may be restricted or delayed while investigations are still under way.

In addition, the sources of information on violent deaths are not traditional ones for public health surveillance systems. The sources of information for maternal mortality surveillance, for example, are almost exclusively health care institutions, organizations with which health departments typically have well-established relationships. In contrast, although the situation is improving gradually, health departments typically have little experience working with law enforcement or medical examiners/coroners. The lack of such relationships can make data access more difficult or less timely.

An additional barrier is that many of the sources of information on violent deaths are non-centralized. Only 16 states and the District of Columbia have centralized medical examiner systems with centralized records; the remainder have county- or district- based medical examiners and/or coroners<sup>ii</sup>. A given state may have dozens to hundreds of local police departments with which to set up data-sharing agreements. Moreover, CME and law enforcement information is not standardized and may not be available electronically. Time consuming abstraction from primary sources by trained abstractors will be required. Eventually efforts to develop an electronic death certificate and efforts by the Department of Justice to develop the National Incident Based Reporting System for police information may reduce the need for data abstraction.

### **3. Methods to Maximize Response Rates and Deal with Non-response**

This issue is not relevant with this methodology.

### **4. Tests of Procedures or Methods to be Undertaken**

States began collecting data for NVDRS in 2003 and has been an ongoing data system in which states continually collect data from existing records. Funded states recently finalized data collection for 2017 and continuing to input data for 2018 and 2019. 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 (Att. 6) with streamlined coding system to facilitate data abstraction efficiency.

### **5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data**

No sophisticated statistical techniques (e.g., weighting) are required to collect or analyze these surveillance data. Aggregated crude and age-adjusted rates for suicide, homicide, undetermined cause of death, legal intervention, unintentional firearm injury, and terrorism will be employed. The percent of different types of violent deaths associated with specific circumstances, e.g., a history of substance abuse, will be presented. Time trends will also be shown. Routine supervision of the analysis of data are with the following:

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The State Unintentional Drug Overdose Reporting System (SUDORS) is a state-based surveillance system developed to provide more timely data on fatal opioid overdoses from vital statistics and coroner/medical examiner records. SUDORS uses the NVDRS web-based system to collect these data. Both NVDRS and SUDORS collect information on drug-related deaths of undetermined intent, although SUDORS does not collect law enforcement data for these incidents. SUDORS has a shorter period for overall data collection than does NVDRS. SUDORS and NVDRS will independently analyze their own data.

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<sup>i</sup>. Goodin J, Hanzlick R. Mind your manners: part II: general results from the National Association of Medical Examiners Manner of Death Questionnaire, 1995. *Am J Foren Med Path* 1997;18:224-227.

<sup>ii</sup>. <https://www.cdc.gov/phlp/publications/coroner/death.html> Accessed on 8/6/2019.