SUPPORTING STATEMENT: PART A

February 6, 2023

Advancing Violence Epidemiology in Real-Time (AVERT)

New

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SUMMARY TABLE

Goal of the study: The goal of this project is to support state health departments to share timely surveillance data on emergency department (ED) visits for all firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions to CDC.

Intended use of the resulting data: Improve local, state, and regional situational awareness of trends in firearm injuries, other violence-related injuries, and mental health conditions to improve violence prevention and response efforts at the local and state levels.

Methods to be used to collect: The project will leverage ED syndromic data already routinely collected by state health departments and the District of Columbia health department through CDC's National Syndromic Surveillance Program (NSSP), which receives near real-time ED data from health departments or their partners on approximately 73% of ED visits in the United States.

The subpopulation to be studied: Individuals who visit an ED to receive treatment for a firearm injury (regardless of intent), other violence-related injuries, and mental health conditions.

How data will be analyzed: Descriptive analyses, such as frequencies and changes in the rate of ED visits involving a firearm injury, other violence-related injury, or mental health condition by region, state, and local jurisdiction, will be conducted. Longitudinal statistical analyses, such as Joinpoint regression, will be used to describe trends. Also, monthly, quarterly, and yearly changes in key indicators will be monitored to identify sharp increases or decreases.

A. JUSTIFICATION

A.1. Circumstances Making the Collection of Information Necessary

This Information Collection Request for the Advancing Violence Epidemiology in Real-Time (AVERT) is submitted under the classification "New" request. The length of data collection requested for OMB-PRA approval is 3 years. The National Center for Injury Prevention and Control (NCIPC) at the Centers for Disease Control and Prevention (CDC) is making this request as authorized by 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 **(Attachment A).**

Background

Advancing Violence Epidemiology in Real-Time (AVERT) data collection integrates, expands, and enhances previous data sharing efforts with public health departments initiated under the Firearm Injury Surveillance Through Emergency Rooms (FASTER) program (1), which provided funding for 10 jurisdictions to share firearm injury-related ED visit data with CDC. The AVERT program will build on the FASTER program and provide funding to a minimum of 10 jurisdictions to conduct routine monitoring of ED visits related to firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions, and to analyze these data in

a timely manner and share these data with CDC. AVERT will ensure participating jurisdictions use their data to track these violent injury outcomes by providing jurisdictions standardized definitions (**Attachment D)**, which can facilitate rapid identification and tracking of ED data on violence.

AVERT leverages existing ED data collection efforts deployed across state health departments through CDC's National ED Syndromic Surveillance program. The Division of Health Informatics and Surveillance (DHIS) in the Center for Surveillance, Epidemiology, and Laboratory Services (CSELS) in CDC operates the National Syndromic Surveillance Program (NSSP) BioSense Platform (OMB #0920-0824) through which state and local health departments share preliminary ED visit data from approximately 73% of ED facilities in the US (>6,000 participating EDs). Key advantages to AVERT compared to initiating a new ED data collection are:

1. AVERT can be rapidly implemented and scaled to all 50 states and the District of Columbia with minimum burden on state health departments because it relies on sharing and improving ED data already being collected by state and local health departments.
2. AVERT leverages instead of duplicating existing CDC work through CDC NSSP and FASTER to rapidly share state and local health departments ED data with CDC.
3. AVERT ensures that state and local health departments are involved in the collection, ownership and use of the ED data collected because they are primarily responsible for responding to local changes in violence-related ED visits, have extensive local knowledge of their local ED data that fosters identification of data quality problems, and are critical partners in developing tools to monitor illnesses and injury (2,3).

All data sharing between CDC and health departments in AVERT is driven by one standardized data forms the *ED violence data form* (**Attachment E**), and CDC cases definitions of overall firearm injury, intentional self-directed firearm injury, unintentional firearm injury, assault-related firearm injury, intimate partner violence, sexual violence, suspected child abuse and neglect, youth violence, and mental health conditions (**Attachment D**).

A.2. Purpose and Use of Information Collection

AVERT will operate in a minimum of 10 jurisdictions that will be funded from September 2023 through August 2028, through which a competitive process that is underway to select the recipients. AVERT will build upon FASTER and continue to establish and maintain local and state information collection of firearm injuries, other violence-related injuries, and mental health conditions, and provide public health partners and the public with more timely and useful violence surveillance data than is currently available. Currently, the FASTER program operates in the 9 states and the District of Columbia, which are funded through August 2023. All 10 of these jurisdictions provide CDC access to their syndromic surveillance data from EDs in CDC's NSSP system. Access to this timely data has improved situational awareness of federal, state, and local health departments of upticks in and trends of firearm injuries. Health departments have used this data to populate state data dashboards (see examples below) and develop alerts for local communities. In addition, health departments have used this data in concert with other

violence data sources, including the National Violent Death Reporting System, to gain a better overall picture of firearm injuries in their communities.

Health departments sharing syndromic surveillance data with CDC will be required to complete the *ED Violence Data Form* (**Attachment E**) on a bimonthly basis using data from existing state and local ED data collection efforts, described previously. The justification and key variables it will collect are described in detail below:

1. Frequency that this data form is reported to CDC: The goal of the program is to have health departments submit bimonthly reports to CDC to detect and respond to upticks or shifts in violence trends in a timely manner.
2. Key variables shared with CDC: Key variables and why they are collected is described in Table 1 below.

Table 1. Justification for sharing key variables with CDC

Variable	Justification for collecting
Count of ED visits related to a firearm injury	• Detect and respond to upticks or shifts in firearm injury trends in a timely manner. • ED visits related to an initial encounter of a firearm injury overall (including unintentional, intentional self-directed, assault, legal intervention, terrorism, and undetermined intent), in addition to an initial encounter of an unintentional firearm injury, intentional self-directed firearm injury, and assault-related firearm injury, will be collected.
Count of ED visits related to other violence-related injuries	• Collection of ED data on other violence-related injuries have been useful in pilot studies (4–7). • ED visits related to intimate partner violence, sexual violence, child abuse and neglect, and youth violence will be collected.
Count of ED visits related to mental health conditions	• Collection of ED data on mental health conditions have been useful in pilot studies (4,8,9). • ED visits related to various mental health conditions, which may increase risk for or be a negative outcome associated with firearm injuries and other violence-related injuries, will be collected, in addition to new syndrome definitions that are developed to monitor mental health-related visits. The current list includes: all mental health-related visits, as well as anxiety, depressive, bipolar, schizophrenia spectrum, trauma- and stressor-related, attention-deficit/hyperactivity, disruptive behavioral and impulse, obsessive-compulsive, eating, and tic disorders.
Sex, age group, race/ethnicity, and county level data by firearm injury, violence-related injury, and mental health indicators	• Aggregating data on firearm injuries, other violence-related injuries, and mental health conditions by sex, age group, race/ethnicity, and county is critical to assist CDC as well as state and local health departments target interventions on demographic groups and geographic areas impacted by upticks or large changes in violence.
Percent of ED visits with chief complaint text and diagnosis codes	• ED visits involving violence are primarily identified by analyzing patient's chief complaint and diagnosis codes fields, primarily ICD-10-CM diagnosis codes. Thus, important data quality indicators are the percent of ED visits with chief complaint data and the percent of ED visits with diagnosis codes.

Variable	Justification for collecting
Median word length of the chief complaint	• The median word length of the chief complaint is tracked because the ability to identify violence is impacted by the length and quality of text data entered into the chief complaint text field. Based on previous experience working with health departments, chief complaints with fewer words are less likely to contain information on the type of injury or intent of the injury.
Mean and maximum number of diagnosis codes	• The mean and maximum of diagnosis codes, primarily ICD-10-CM diagnosis codes, collected by jurisdictions varies (e.g., one jurisdiction may allow hospitals to enter 10 codes while another allows 16 codes). Since CDC violence case definitions search all diagnosis codes, tracking the number of submitted diagnosis codes is important because they may result in slight differences between jurisdiction ability to identify violence-related visits (e.g., jurisdictions collected more ICD-10-CM codes might be slightly more likely to identify an ED visit as involving a firearm injury).
Metadata on local surveillance systems	• Local ED data systems may experience major changes that impact data quality (e.g., ED data sharing delayed due to the implementation of a new EHR system). To effectively identify and address these types of changes, AVERT will ask all participating health departments to report major changes in ED participation or data quality bimonthly.

Use of the data form by CDC

CDC will use this data form to rapidly identify changes in the frequency of all firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions, and to identify geographic areas and populations within a state that are experiencing high burden to inform violence prevention and response efforts.

Example state data dashboards

1. Virginia FASTER data dashboard: https://www.vdh.virginia.gov/surveillance-and-investigation/syndromic-surveillance/firearm-injury-surveillance/
2. Georgia FASTER data dashboard: https://dph.georgia.gov/faster-ga
3. North Carolina FASTER data reports: https://ncdetect.org/nc-faster-firearm-quarterly-reports/

Data from FASTER has also raised public awareness of changes in firearm injury-related ED visits, particularly following the onset of the COVID-19 pandemic. FASTER data has been used in several publications (see below list).

Example publications

1. Van Dyke ME, Chen MS, Sheppard M, et al. (2022). County-Level Social Vulnerability and Emergency Department Visits for Firearm Injuries — 10 U.S. Jurisdictions, January 1, 2018–December 31, 2021. *Morbidity and Mortality Weekly Report*. DOI: http://dx.doi.org/10.15585/mmwr.mm7127a1.
2. Radhakrishna L, Carey K, Hartnett KP, et al. (2022). Pediatric Emergency Department Visits Before and During the COVID-19 Pandemic — United States, January 2019–January 2022. *Morbidity and Mortality Weekly Report.* DOI: http://dx.doi.org/10.15585/mmwr.mm7108e1.

3. Zwald ML, Holland KH, Bowen DA, et al. (2022). Using the Centers for Disease Control and Prevention's National Syndromic Surveillance Program Data to Monitor Trends in U.S. Emergency Department Visits for Firearm Injuries, 2018-2019. *Annals of Emergency Medicine.* DOI: 10.1016/j.annemergmed.2022.01.016.

A.3. Use of Improved Information Technology and Burden Reduction

CDC will utilize special data/information collection procedures with the AVERT program which leverage improved information technology and helps to reduce burden on participating health departments in the following ways:

1. Data from over 6,000 hospitals and around 73% of ED visits in the US is currently shared with CDC through the NSSP BioSense platform. Just three years ago, NSSP included a little over 4,000 hospitals with around 60% coverage. Since 2016, the primary computer program used to process and analyze this data is the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) (OMB #0920-0824). AVERT expects that a minimum of 10 health departments will provide CDC access to their ED data within the NSSP BioSense platform using ESSENCE. On at least a bimonthly basis, CDC AVERT staff will use its access to abstract information to complete the *ED violence data form*. Participating health departments will only be asked to verify the accuracy of the CDC generated reports by reviewing the ED data included in the report and support CDC completing of the *ED violence data form* metadata. CDC production of the reports greatly reduces burden on participating health departments. Two other advantages of sharing case-level ED data through this platform are:
    a. NSSP BioSense is constantly improving their data sharing platform and analysis tools, such as ESSENCE. This data collection effort will continue to leverage these improvements as they are implemented by CDC.
    b. CDC AVERT staff are closely collaborating with the CDC NSSP BioSense team and NCIPC Office of Informatics to better automate analysis of firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions. This includes creating tools to help CDC as well as state and local health departments identify and respond to data quality issues. Additionally, local and state health departments will be able to apply the standardized AVERT definitions, available for use in the CDC NSSP BioSense platform (**Attachment D**), of firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions to identify trends in their local ED data in near-real time.

2. AVERT will require that the health departments share ED data using the *ED violence data form* and standard CDC case definitions, available for use in the CDC NSSP BioSense platform (**Attachment D**). The *ED violence data form* is an Excel template, which reduces burden on participating health departments in the following ways:
    a. Enables health departments to create computer programs and standard operating procedures for sharing the data with CDC using CDC's standard format. State health departments have requested CDC design and adhere to standard data sharing protocols.
    b. Excel is widely used and most likely will not require staff from participating health departments to acquire new training,

c. Many statistical programs can export data into Excel,
d. Manual data entry is user friendly, and
e. CDC staff can build multiple automated data quality checks into the Excel data sheet that capture data errors early and prevent the need and burden on participating health departments of submitting revised reports to CDC.

3. All participating health departments will share the *ED violence data form* with CDC using a NCIPC interface hosted on the CDC Secure Access Management Service (SAMS) Partner's Portal (https://sams.cdc.gov), referred to as the NCIPC Partner's Portal (10). Two advantages of the NCIPC Partner's Portal are:
   a. The NCIPC Partner's Portal will improve data quality and reduce burden on participating health departments by automatically identifying data submission errors by participating health departments. Real-time identification of data submission errors enables rapid fixes and reduces the chance participating health departments will need to make multiple data submissions to CDC.
   b. The NCIPC Partner's Portal is a website designed to provide centralized access to external users (e.g., state and local health departments) to data and computer applications operated by CDC. The NCIPC Partner's Portal leverages the CDC SAMS Partner's Portal because CDC SAMS is an established secure method for sharing data that is widely used by state and local health departments. Thus, the time required to gain access and use of the portal will be minimal.

A.4. Efforts to Identify Duplication and Use of Similar Information

AVERT maximizes the use of federal government data by leveraging ED data already collected by the NSSP BioSense platform (mentioned previously in *A1. Circumstances Making the Collection of Information Necessary)* and communicating on an ongoing basis with other federal collections of ED data. CDC's Division of Violence Prevention (DVP) is engaged in an intensive collaboration with the DHIS, the CDC division that operates NSSP BioSense. The collaboration enhances rapid surveillance of firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions by leveraging the approximately 73% of ED facilities in the US that are shared by local health departments or their partners with CDC through the NSSP BioSense Platform.

CDC requires that participating health departments share ED data with CDC through the NSSP BioSense platform. The NSSP BioSense platform is the required mechanism because it minimizes burden on participating health departments by allowing CDC to complete the *ED violence data form* while maximizing data quality by enabling collaborative analyses between CDC and health departments. In CDC's Advancing Violence Epidemiology in Real-Time Notice of Funding Opportunity (AVERT, CDC-RFA-CE-23-0007), DVP included the following required eligibility criteria: (1) Use of the national ESSENCE platform for their syndromic surveillance data management; and (2) Collects and accesses ED visit data from a minimum of 80% of ED facilities in their jurisdiction. This includes ED visit data from a minimum of 90% of Level 1-3 trauma centers.

DVP identified other federal programs collecting ED data to ensure coordination and avoid duplication. Three federal government data systems in addition to NSSP BioSense were identified as potentially overlapping with the current data collection. In Table 2 below, a brief description of each data system is provided as well as why AVERT is not duplicative with the data collection.

Table 2. Other ED data systems and justification for additional value of AVERT

ED data system	Description	Time lag	Purpose of ED system	Additional Value of AVERT
Health Care Utilization Project (HCUP) Nationwide Emergency Department Sample (NEDS) administered by the Agency of Healthcare Research and Quality (AHRQ) (11)	37 states contribute data to NEDS. In 2016, the database contains a sample of around 33 million ED visits that can be used to make national estimates of ED visits involving specific illnesses and injury. Key data include ICD-10-CM diagnosis and procedure codes as well as medical charge and patient demographics.	~ 2 years	NEDS data are used to estimate the national burden of ED visits related to violence-related injuries.	AVERT includes state-level and county-level data that can be used by communities to detect and respond to upticks or shifts in violence trends in a timely manner. AVERT data will be rapidly available (within 1-2 months of an ED visit) and can thus inform more rapid response to changes in local, state, and regional violent injuries.
Health Care Utilization Project (HCUP) State Emergency Department Databases (SEDD) administered by the Agency of Healthcare Research and Quality (AHRQ) (12)	SEDD includes all ED visits that did not result in a hospitalization from about 37 states. Data and access conditions vary across state. As of May 1, 2019, 22 states provided access to 2016 data and 11 states provided access to 2017 data.	~ 2-3 years	SEDD data are used to estimate the burden of ED visits related to violence by state. Only a subset of states provides public access to their data.	AVERT data will be rapidly available (within 1-2 months of an ED visit) and can thus inform more rapid response to changes in local, state, and regional violent injuries. AVERT will provide timelier and more comprehensive regional and national situational awareness of violence trends as more states will publicly report

ED data system	Description	Time lag	Purpose of ED system	Additional Value of AVERT
				violence trends.
National Electronic Injury Surveillance System –Firearm Injury Surveillance Study (NEISS-FISS) project conducted by CDC in collaboration with FDA and Consumer Product Safety Commission (13)	NEISS-NFISS collects nationally representative data from a sample of under 100 hospitals and uses trained coders to conduct narrative reviews of medical records for firearm-related injury cases treated at participating hospitals.	~1 to 2 years	NEISS-NFISS data are used to estimate the national burden of ED visits related to firearm injuries. The system cannot make regional or state estimates and does not collect information other violence-related injuries or mental health conditions.	AVERT works to provide timely local and regional situational awareness of the violence upticks and trends in a timely manner. AVERT will capture information on additional violence-related injuries and mental health conditions.

As AVERT is implemented, DVP will communicate with other federal ED data collections to avoid duplication and identify opportunities for collaboration. Possible opportunities for collaboration include comparisons of AVERT findings with HCUP, SEDS, and FISS findings in similar geographic areas or hospitals could help inform revisions and improvements in AVERT's syndrome definitions of ED visits involving firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions (**Attachment D**).

A.5. Impact on Small Businesses or Other Small Entities

This data collection will not involve small businesses.

This study does not impact small businesses or other small entities. It impacts state health departments and the District of Columbia whose ED records will be shared with CDC.

A.6. Consequences of Collecting the Information Less Frequently

If AVERT collects data less frequently, the following adverse consequences will occur:

- Federal and state governmental situational awareness of trends in violence-related ED visits will be substantially slowed. This will erode the ability of federal agencies and state health departments to rapidly respond to upticks or shifts in violence. Without bimonthly national data sharing between participating health departments and CDC through AVERT, implementation of public health interventions will lag.
- Public situational awareness on changes in firearm injuries, violence-related injuries, and mental health conditions will be substantially slowed. This may slow intervention efforts by non-governmental organizations and citizens. Currently, limited timely local and state data are available on fatal and nonfatal firearm injuries, violence-related injuries, and mental health conditions. The National Center for Health Statistics publishes provisional death data on firearm-related injuries from death certificates with a 7-month delay (14). These data, however, are only available at the state-level, reports a 12-month rolling average which will

be slow to detect change, and does not provide any information by demographic groups. National and state hospital discharge data on ED visits for violence-related injuries is available from the HCUP, with a 2–3-year delay and it is not available for all states (11).

- Local health department surveillance and response to firearm injuries, other violence-related injuries, and mental health conditions would be diminished. First, there would be a longer time lag in local health departments learning about how their locality's trends in violence align within their state- or regional- trends. Second, AVERT reporting is accompanied by data quality efforts. Reducing the frequency of these data quality efforts would likely lead to less timely and effective identification of data quality problems that could diminish the ability of a local health department to accurately detect upticks in violence.

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

This data collection will require bimonthly reporting of aggregate ED data on firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions using the *ED violence data form*. This is more rapid than quarterly data sharing recommended by OMB. Bimonthly sharing of ED data is critical to fulfill the mission of AVERT, which is to detect and respond to upticks or shifts in violence trends in a timely manner. Without bimonthly national data sharing between participating health departments and CDC through AVERT, response and violence prevention efforts will continue to fall far behind.

AVERT works to mitigate the burden of bimonthly reporting on participating health departments by:

1. Providing funding to participating health departments to offset burden related to completing required data sharing form, the *ED violence data form*, on a bimonthly basis.
2. Providing substantial technical assistance to participating health departments in completing reports. This includes CDC staff completing the *ED violence data form* each month for the estimated 10 health departments sharing case-level ED with CDC through NSSP BioSense.

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

A.8.a) Federal Register Notice

A 60-day Federal Register Notice was published in the Federal Register on March 24 ,2023 vol. 88 No. 57, pp. 17850 (**Attachment B**). There was one non-substantive comment to the 60-day Federal Register Notice (**Attachment B1**).

A.8.b) Efforts to Consult Outside the Agency

NCIPC's DVP is currently receiving feedback from state public health departments and the District of Columbia on improving rapid ED surveillance of firearm injuries (regardless of intent), other violence-related violent injuries, and mental health conditions. NCIPC's DVP also consulted with NCIPC's Division of Overdose Prevention (DOP) and Division of Injury Prevention (DIP), and CSELS's DHIS, to learn from and avoid duplication with other federal

government efforts to collect data on ED visits related to violence (mentioned previously in *A.4.Efforts to Identify Duplication and Use of Similar Information*).

A.9. Explanation of Any Payment or Gift to Respondents

Public agencies (i.e., the respondents) will not receive payments or gifts for providing information.

A.10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

The CDC Office of the Chief Information Officer has determined that the Privacy Act does not apply to this information collection request (**Attachment F**).

Four main strategies will be implemented to maintain the confidentiality of the data:

1. State health departments and the District of Columbia (the respondents) will only share with CDC aggregate data collected on one standardized form: the *ED violence data form.* Although CDC will have access to case-level ED data through NSSP BioSense for all health departments to automate completion of the *ED violence data form*, CDC will only report on aggregate ED data entered into the *ED violence data form.* Case-level ED data will only be used by CDC to assist public health departments complete the *ED violence data form* on a bimonthly basis and help health departments and CDC improve data quality and identification of firearm injuries, other violence-related injuries, and mental health conditions.
2. Participating health departments will access and submit the *ED violence data form* to CDC using the NCIPC Partner's Portal hosted on the CDC Secure Access Management Service (SAMS) site (10). The CDC SAMS Partner's Portal is a web site designed to provide secure centralized access to external users such as public health departments to data and computer applications operated by CDC. It can also be used to securely exchange data between CDC and participating health departments.
3. Only selected staff working in the AVERT program will have access to aggregate data entered into the *ED violence data form* by participating health departments. Also, Excel files as well as analytical statistical files will be stored and managed on secure CDC servers.
4. AVERT will follow NCHS guidelines on suppression of small sample sizes in data tabulations (e.g., not report any information that involves between 1 and 9 people) to prevent the inadvertent identification of an individual through the combination of various demographic characteristics.

A.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 the activity is not research and IRB approval is not required. This data collection is a surveillance effort and human subjects will not be involved (**Attachment C**).

Sensitive Questions

This data/information collection does not involve the collection of information of any questions of sensitive nature.

A.12. Estimates of Annualized Burden Hours and Costs

This data collection includes on data form:

ED violence data form (**Attachment E**) supports rapid bimonthly ED surveillance of firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions to detect and respond to upticks or shifts in violence trends in a timely manner. The *ED violence data form* includes calculations of the total number of ED visits for overall firearm injury, intentional self-directed firearm injury, unintentional firearm injury, assault-related firearm injury, intimate partner violence, sexual violence, suspected child abuse and neglect, youth violence, and mental health conditions that occurred each month by county and by age, sex, and race/ethnicity. Also, jurisdictions will be asked to provide metadata including coverage of the local ED surveillance system (i.e., percentage of all ED visits captured by the jurisdiction's ED surveillance) and recent major changes in the local ED data collection efforts (e.g., large number of hospitals begin or terminate participation).

CDC expects all of the funded health departments to provide CDC access to case-level ED data through the NSSP BioSense Platform (OMB #0920-0824). Using the case-level data, CDC will complete the vast majority of the *ED violence data form* including calculating the total number of ED visits for overall firearm injury, intentional self-directed firearm injury, unintentional firearm injury, assault-related firearm injury, intimate partner violence, sexual violence, suspected child abuse and neglect, youth violence, and mental health conditions that occurred each month by county and by age, sex, and race/ethnicity. CDC, however, will consult with the jurisdiction when completing metadata and this will result in a small burden. Based on CDC collaborative work with health departments using the NSSP BioSense Platform, the burden will be .5 hours per bimonthly report per jurisdiction. Thus, the annual burden per health department will be 3 hours (.5 hours x 6 months) or a total of 30 burden hours across the 10 responding health departments (Table 3).

Table 3. Estimates of annualized respondent burden hours

Type of respondent	Form name	No. of respondents	Total no. of responses per respondent	Average burden per response (hours)	Total annual burden (hours)
Participating health departments sharing case-level ED data with CDC through the NSSP BioSense (OMB #0920-0824)*	ED form (*ED violence data form*)	10	6	30/60	30
Total					30

* The reporting burden for jurisdictions sharing case-level ED data with CDC is substantially lower because CDC completes most of the form for the jurisdiction and only needs to consult with the jurisdiction on completing the metadata.

Estimates of annualized respondent burden costs:

Because staff retrieving and sharing specified data with CDC will vary substantially across organizations, the mean hourly wage of federal, state, and local government employees ($30.85) as estimated by the Bureau of Labor Statistics (https://www.bls.gov/oes/current/999001.htm#00-0000, accessed on 02Feb2023) was used to estimate burden costs (Table 4).

Table 4. Estimates of annualized respondent burden costs

Type of respondent	No. of respondents	No. of responses per respondent	Total burden (hours)	Hourly wage rate	Total respondent cost
Participating health departments sharing case-level ED data with CDC through the NSSP BioSense (OMB #0920-0824)*	10	6	30	$30.85	$926
Total					$926

* The reporting burden for jurisdictions sharing case-level ED data with CDC is substantially lower because CDC completes most of the form for the jurisdiction and only needs to consult with the jurisdiction on completing the metadata.

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

There will be no annual cost burden to respondents or record keepers resulting from this data/information collection.

A.14. Annualized Cost to the Government

AVERT costs to the government are described in Table 5.

Table 5. AVERT Government Costs

Personnel	Tasks	Avg. cost/yr.
Senior Scientist (50%)	• Program oversight and strategic direction	$80,000

2 Epidemiologists (75%)	• Technical assistance and data usage	$156,000
2 Public Health Advisors (75%)	• Programmatic, budgetary, administrative management & oversight	$167,000
1 Data Manager (100%)	• Manage and curate bimonthly data submitted • Implement system to rapidly and automatically identify data quality problems that need follow-up, perform preliminary analyses, and transform data for rapid posting to the public. • Engage in continuous quality improvement to enhance data quality and analysis in collaboration with epidemiologist.	$120,000
Annualized federal costs		**$523,000**

AVERT is a multi-year project, with most initial cooperative agreements spanning five years. Ongoing surveillance activities will include recurring data collection, monitoring of data quality, and preparation and analysis of survey results. The government costs are the personnel costs of federal staff involved in oversight, design, and analysis. No outside contractors will be used. There will be no printing or publication costs for the government.

A.15. Explanation for Program Changes or Adjustments

"This is a new data/information collection."

A.16. Plans for Tabulation and Publication, and Project Time Schedule

Monthly, quarterly, and yearly trends in ED visits involving firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions (which may increase risk for or be a negative associated with firearm injuries and other violence-related injuries) at the state-level will be reported publicly on an ongoing basis by CDC. Additional analyses examining data by age group, sex, race/ethnicity, and county will also be conducted as well as comparison of ED trends with other data sets, such as violent death data. These additional analyses will be released in CDC publications such as *MMWR* or in other peer-reviewed publications as well as available every six months on a future violence surveillance website. A project time schedule is presented in Table 6 below.

Table 6. Time Schedule

Task	Time Period
Receive on a bimonthly basis (*ED violence data form*) from the jurisdiction	2 – 3-month after OMB approval and continuously
Final analysis files validated within 1 month of receipt of data from jurisdiction. Preliminary data is shared with participating health department and CDC/HHS leadership	4 – 5-month delay from when the ED visit occurred
At least once a year, quarterly or monthly changes in ED	6 – 12-months from when the ED visit

visits involving firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions will be posted on the web for public access	occurred
Publish surveillance reports and epidemiologic analyses of AVERT data to support public health prevention efforts	
Analyze trends in ED visits to identify important patterns to inform public health action and improve syndromic ED definitions of firearm injuries (regardless of intent), other violence-related injuries, and mental health conditions	At least two articles per year will be published, starting 1 year after the AVERT system begins operating.
Conduct analyses to support improved data collection and analysis	
Conduct ongoing analysis of metadata submitted by jurisdictions to inform improvements to data collection	These analyses will start 6 months after the AVERT system begins operating and sufficient data is available.

Future publications will focus on:

- Identifying patterns of ED visits for firearm injuries (regardless of intent), other types of violence-related injuries, and mental health conditions, and examining how these patterns vary across demographic groups to better target interventions.
- Assessing relationships between health inequities and social determinants of health and ED visits for firearm injuries (regardless of intent), other types of violence-related injuries, and mental health conditions.
- Comparing state and national trends in ED visits involving firearm injuries (regardless of intent), other types of violence-related injuries, and mental health conditions with trends observed in violence-related deaths. This will help validate and improve the current data collection.

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

There are no standard paper data collection forms to be used in this data collection. Instead, the participating health departments share the requested ED data with CDC using an Excel file, the *ED violence data form*. The OMB number will be displayed on the *ED violence data form* distributed to state health departments.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.