

***SUPPORTING STATEMENT: PART A***

**December 23, 2025**

**State Unintentional Drug Overdose Reporting System (SUDORS)**

OMB# 0920-1128

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### Summary Table

- **Goal of the study** – Continue collecting data for State Unintentional Drug Overdose Reporting System (SUDORS) – Detects state and local community changes in unintentional and undetermined intent drug overdose mortality and provides in-depth state and local (e.g., county) information on risk factors for drug overdose deaths that can inform the selection and targeting of interventions in all 50 states, and the District of Columbia. CDC requests OMB approval for

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intend drug overdoses to support prevention and response efforts. Specifically, participating health departments must abstract medical examiner and/or coroner (ME/C) data and death certificate (DC) data on CDC required data elements into SUDORS (Attachment D, E) including modifications to some data elements (Attachment E).

Over 100,000 people per year died of drug overdoses in each of 2021, 2022, and 2023 in the US (106,699, 107,941, and 105,007 deaths, respectively).<sup>1</sup> Recent data indicate that drug overdose deaths started declining in most states in 2024; however, trends vary by state and different population groups, and in some places deaths started increasing again in 2025.<sup>2</sup> SUDORS data contain information about circumstances surrounding overdose deaths, and about the medical and social history of people who died of drug overdoses; it is important to collect the data to inform overdose prevention and response efforts.

## **Background**

In response to the growing severity of the opioid overdose epidemic, the US government first declared the opioid overdose epidemic a public health emergency on October 26, 2017.<sup>3</sup> In March 2025, the public health emergency declaration was renewed,<sup>4</sup> and in April 2025, the Administration released a Statement of Drug Policy Priorities<sup>5</sup> outlining 6 top priorities: 1) Reduce the number of overdose fatalities, with a focus on fentanyl; 2) Secure global supply chain against drug trafficking; 3) Stop the flow of drugs across our border and into our communities; 4) Prevent drug use before it starts; 5) Provide treatment that leads to long-term recovery; and 6) Innovate in research and data to support drug control strategies. SUDORS is a critical element of the 6<sup>th</sup> priority to innovate in research and data, and data from SUDORS can be used to help inform efforts for the 1<sup>st</sup> priority to reduce overdose deaths.

The SUDORS system provides specific information on drugs contributing to an overdose as well as detailed information on risk factors for unintentional and undetermined intent (i.e., evidence equally supported or could not distinguish between two possible intents such as unintentional or suicide) drug overdose (UUDO) deaths. Risk factors include recent discharge from residential treatment or prison, recent arrest, recent return to using opioids or other drugs, using drugs while alone, mental health conditions, using highly potent synthetic drugs like illegally-made fentanyl, and new patterns in polysubstance drug use. These risk factors can be tracked at the regional, state, or local level (e.g., county and zip code). The following characteristics of the drug overdose epidemic make it critical to track the specific drug(s) contributing to drug overdose deaths: 1) illegally-made fentanyls are the leading drugs contributing to overdose deaths;<sup>6,7</sup> 2) the involvement of stimulants in overdose deaths have increased in recent years, most often co-involved with opioids;<sup>8</sup> and 3) the drug supply is very fluid, with potent synthetic opioids like nitazene analogs emerging<sup>9</sup> and different fentanyl adulterants like xylazine and medetomidine<sup>10</sup>

cycling in and out.

Interventions that could be used by communities to address the risk factors tracked by SUDORS include distributing naloxone<sup>11</sup> to first responders and community members, enhancing access to and use of evidence-based substance use disorder treatment,<sup>12</sup> and implementing the 2022 Clinical Practice Guideline<sup>13</sup> for treating short- and long-term pain.

SUDORS leverages the existing web-based data collection platform, the National Violent Death Reporting System (NVDRS) OMB# 0920-0607, to collect medical examiner and coroner (ME/C) information, including toxicology, and death certificate information on unintentional and undetermined intent fatal drug overdoses. 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 (See Attachment A).

## **2. Purpose and Use of Information Collection**

The purpose of this renewal request is to continue collecting data for SUDORS to generate public health surveillance information on unintentional and undetermined intent drug overdose deaths across multiple states, within a state, and within local communities. These data support states and local communities to better select and tailor intervention strategies that address the risk factors driving fatal drug overdoses in their community. Key usage of SUDORS data is provided below:

- Assist state and local communities to better understand the extent to which drug overdose deaths are related to the misuse of prescription drugs versus use of illegal drugs such as heroin and illegally-made fentanyl. For example, postmortem toxicology testing results and scene evidence (e.g., drug paraphernalia) only available on ME/C reports are often needed to determine whether drug overdoses testing positive for morphine are related to the use of prescription morphine or heroin.
- Help states focus on counties and zip codes experiencing increasing opioid-involved deaths for the distribution of opioid overdose reversal medications, such as naloxone.
- Support state and local communities to identify opportunities to intervene before a fatal overdose occurs by examining the decedents' contacts with key institutions in close proximity to the overdose including: 1) percent of decedents who were receiving treatment for substance use and/or mental health disorders, 2) the percent of decedents who had a recent emergency department visit, and 3) the percent of decedents who were released from an institutional setting (e.g., jail/prison, in-patient rehabilitation) within the last month, a risk factor for overdose.
- Inform state and local health departments about shifts in the drug supply (e.g., influx in counterfeit pills containing illegally-made fentanyl<sup>14</sup>) or polysubstance use patterns emerging in overdose deaths. Understanding this issue could inform public health and emergency medical response.
- Determine whether fatal overdoses are related to how the drug was taken (e.g., injected, swallowed, sniffed, smoked, etc.) so interventions can be tailored to groups most at risk of a fatal overdose.<sup>15</sup>

CDC obtained OMB approval in 2022 for a revision to make the following changes: 1) remove data collection activities in Puerto Rico, and 2) update the burden estimate to reflect the increase in drug overdose deaths. A change request was also approved in March 2025 to make changes to the data collection platform to align with EO 14168 Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government.

The data obtained during the 2022 approved changes were used for six publications and multiple presentations. The information was useful for highlighting the following, which is information not available through other CDC data systems:

- During January 2021–June 2024, 59.0% of overdose deaths involved stimulants, 43.1% co-involved stimulants and opioids, and 15.9% involved stimulants and no opioids. Persons who died of overdoses involving stimulants and no opioids were older and more frequently had a history of cardiovascular disease than those who died of overdoses involving stimulants and opioids. Expanded access to evidence-based treatments for stimulant use disorder, evaluation of medication-based treatments, and engagement of persons using stimulants who might be missed by opioid-focused efforts might reduce deaths.<sup>16</sup>
- Overdose deaths overall and with IMFs detected began declining in 2023. Percentages of overdose deaths with IMFs detected were stable (approximately 70%–80%) during 2021–2024, except in the West where the percentage increased from 48.5% to 66.5%. Overdose prevention efforts that address widespread presence of IMFs, including carfentanil, and can rapidly adapt to other potent opioids in the drug supply, might result in lasting reductions in overdose deaths across the United States.<sup>17</sup>
- During July 2019–June 2023, ketamine was detected in <1% of overdose deaths and was the only drug involved in 24 deaths. During this period, the percentage of overdose deaths with ketamine detected in toxicology reports increased from 0.3% (47 deaths) to 0.5% (107 deaths). Further investigation is needed to better understand the role of ketamine in drug overdoses, particularly when multiple substances are used before death.<sup>18</sup>
- In 2022, 22% of persons who died of drug overdose had a non–substance-related mental health disorder. Approximately one quarter of decedents with a non–substance-related mental health disorder had at least one recent potential opportunity for intervention. Implementing evidence-based screening for substance use and mental health disorders during potential intervention opportunities and expanding efforts to integrate care for these disorders could improve mental health and reduce overdoses.<sup>19</sup>
- From January–June 2020 to July–December 2022, the percentage of overdose deaths with evidence of smoking increased 73.7%, and the percentage with evidence of injection decreased 29.1%; similar changes were observed in all U.S. regions. Strengthening and expanding public health and harm reduction services to address overdose risk with smoking and other noninjection routes might reduce deaths.<sup>20</sup>
- Evidence of counterfeit pill use in overdose deaths more than doubled from July–September 2019 to October–December 2021, and tripled in western U.S. states. Decedents with evidence of counterfeit pill use, compared with those without such evidence, were younger, more often Hispanic or Latino, and more frequently had a history of prescription drug misuse and drug use by smoking. Overdose prevention messaging that highlights the dangers of pills obtained illegally or without a prescription,

encourages drug product testing by persons using drugs, and is tailored to persons most at risk (e.g., younger persons) could help prevent overdose deaths.<sup>21</sup>

- Among 21 jurisdictions, the monthly percentage of IMF-involved deaths with xylazine detected increased 276% from January 2019 (2.9%) to June 2022 (10.9%). During January 2021–June 2022 in 32 jurisdictions, xylazine was detected in a higher percentage of IMF-involved deaths in the Northeast U.S. Census Bureau region; listing xylazine as cause of death varied across jurisdictions. Routine xylazine testing in suspected overdose deaths is critical for surveillance; further investigation of xylazine’s effects on humans is needed to guide prevention efforts. Overdose prevention and response messages should emphasize the need to seek treatment beyond naloxone administration.<sup>22</sup>
- Median monthly overdose deaths among persons aged 10–19 years (adolescents) increased 109% from July–December 2019 to July–December 2021; deaths involving illicitly manufactured fentanyl (IMFs) increased 182%. Counterfeit pills were present in nearly 25% of deaths. Educating adolescents about the dangers of IMFs and counterfeit pills, working with public safety to reduce availability of illicit drugs, and ensuring access to evidence-based substance use and mental health treatment could save lives.<sup>23</sup>

This request has the following minor revisions: 1) implement updates to the web-based system to improve performance, functionality, and accessibility; and 2) add new data elements to the system. These revisions do not affect the burden estimates.

The updates to the web-based system are as follows:

- Software Enhancements: While not involving any changes to data elements collected, software enhancements have improved functionality in the Toxicology module of the system, record validation, and data import.
- Dashboard modifications: The Victim Data Quality report was updated to reflect revised standards for timely initiation of SUDORS cases. In addition, it shows data of victims with circumstances from multiple data sources to better reflect the standard for inclusion in the national dataset.
- Bulk record validation: this function generates error reports on demand for incidents that do not meet SUDORS quality standards. It gathers all the error, warning, and quality messages together into a single CSV formatted text file that can be opened in Excel or any number of programs.
- Toxicology modifications: To give programs better control over the ordering of substances entered on the Toxicology Findings, a function was added to allow users to move substances up and down. This makes it easier for programs to ensure substances are entered in the same order as they appear on a toxicology report.

The new data elements added to the system as part of a web-based system software update (version 2.7) are as follows:

- Changes to Race and Ethnicity Data Elements: To bring SUDORS into alignment with the U.S. Standard Certificate of Death developed by the National Center for Health Statistics ([NVSS - Revisions of the U.S. Standard Certificates and Reports](#)), detailed sub-categories have been added to the “Asian” and “Native Hawaiian or Other Pacific Islander” categories. The Asian category will now include: Asian Indian, Chinese,

Filipino, Japanese, Korean, Vietnamese, and Other Asian. The Native Hawaiian or Other Pacific Islander category will now include: Native Hawaiian, Guamanian or Chamorro, Samoan, and Other Pacific Islander. There are plans to make necessary revisions to the data elements to comply with the *Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity* (SPD 15) by March 28, 2029;

- Place of Death: In addition to the state of death, which has been collected from the start of SUDORS, the County of Death has been added;
- Changes to Mental Health and Substance Abuse Data Elements: Data elements that have grouped mental health and substance abuse treatments together were expanded to distinguish the two. “Current mental health/substance abuse treatment” was expanded with two child elements, “Current treatment for mental health problem” and “Current treatment for substance use/misuse problem.” Similar expansions have been made to the elements “Ever treated for mental health or substance abuse problem” and “Non-adherence to mental health/substance abuse treatment.”
- Data elements have been added to the OD (“Overdose”) tab to better collect information about circumstances surrounding overdose deaths that previously were captured in text-based incident narratives.
- Creation of a new Rapid Reporting Feature: This feature is in development. All of these aforementioned modifications to system software are detailed with screen captures in Attachments E.

### **3. Use of Improved Information Technology and Burden Reduction**

Data entry is accomplished by all funded health department offices via the secure NVDRS/SUDORS web-based platform. Data are continuously transmitted via the web to a secure CDC-based server. This has four advantages:

1. The web-based platform enhances the ability of authorized users to securely enter the data from multiple sites or directly from coroner or medical examiner offices.
2. Because participating health departments use the same web-platform to enter information on violent deaths through NVDRS, participating health departments can increase efficiency and decrease burden by designing similar data collection and data abstraction processes across violent and drug overdose deaths.
3. Training of new data abstractors is simplified for NVDRS-funded jurisdictions because they can build on the historical experience of using the NVDRS web platform.
4. Participating health departments with access to electronic data can reduce data entry burden by using electronic import options for death certificate and ME/C data. CDC is working to further reduce burden by expanding current electronic import functionality to also accept postmortem toxicology testing data.

The web-based data collection platform also improves data quality by including internal validation checks and other quality control measures that capture data entry errors as they occur. This reduces the burden because identifying and fixing errors after data entry is complete is more difficult and less timely.

### **4. Efforts to Identify Duplication and Use of Similar Information**

There is no similar ongoing surveillance system to SUDORS in existence. SUDORS, however, enhances its data collection by leveraging the web-based data collection system used by the National Violent Death Reporting System (NVDRS) and collaborating with the National Center for Health Statistics (NCHS) to improve the timeliness of death certificate data on drug overdose deaths. Both collaborative efforts are described below, including how SUDORS is distinct from NVDRS and death certificate data collected by NCHS.

### **SUDORS coordination with the National Violent Death Reporting System (NVDRS)**

The purpose of NVDRS is to collect data on violent deaths (i.e., homicides and suicides) and circumstances associated with violent deaths (e.g., arguments, financial distress, or intimate partner problems). SUDORS captures drug overdose deaths that are unintentional or of undetermined intent; unintentional overdose deaths are outside the scope of NVDRS, and although NVDRS would also capture undetermined intent overdose deaths, those deaths are only entered once in the system and both programs pull them into their own data. Thus, SUDORS is not duplicative of NVDRS. Also, SUDORS will collect unique information on drug overdose deaths such as the route of administration of the drug(s) contributing to the fatal overdose (e.g., injection), the presence of bystanders at the overdose scene, scene evidence of illegal or prescription drug use, and the administration of naloxone by first responders that is not collected on violent deaths by NVDRS.

SUDORS is a new data collection instead of an amendment to NVDRS because the purpose of SUDORS is different from NVDRS. This results in the programs having different requirements, imposing different burdens on the public, and becoming more distinct overtime. With the specific drugs involved in drug overdose deaths shifting quickly (e.g., fentanyl and fentanyl analogs), SUDORS needs to collect data with a shorter time lag to be effective (data are due twice per year, on a lag of 7–13 months after the date of death). This is substantially faster than current NVDRS timelines. To achieve more rapid reporting, SUDORS is not collecting law enforcement information, which has a long-time lag even though NVDRS does collect this information. This means the burden estimates for the two systems will be different. Although SUDORS currently collects many of the same variables as NVDRS, the information that SUDORS collects is expected to change over time based on feedback from recipients and key stakeholders. This will result in SUDORS including additional variables and dropping other variables (i.e., grayed or blanked out in the data entry system). In fact, the previous revisions of SUDORS have demonstrated rapid expansion and enhancement of information collected on drug overdose deaths. These changes increasingly make the data collected by SUDORS and NVDRS different. Also, SUDORS may explore additional linkages with data sources such as state prescription drug monitoring programs (i.e., state programs that track all controlled substance prescriptions) that are very relevant to drug overdose, but not as useful to NVDRS. This again would contribute to significant differences in scope and burden estimates of the two systems.

SUDORS is using the NVDRS web-based platform instead of creating a new data collection system to both reduce burden on respondents and maximize federal government resources. Specifically, two advantages of using the NVDRS web-based platform instead of creating a new data collection system are the following:

- 1) Staff at many local public health departments have already received trained in accessing

and using the NVDRS web-based system. These staff also receive trainings on new NVDRS web functionality. By leveraging NVDRS historical and ongoing training, SUDORS reduces the training burden on staff in many health departments participating in SUDORS,

2) The use of the NVDRS web-based platform also substantially reduces CDC development and maintenance costs such as being compliant with ongoing security and privacy standards compared to developing a new system. NVDRS has been designed to support abstraction of standardized data elements from death certificates and ME/C reports that SUDORS will collect (e.g., demographic description of decedents, toxicology reports, and location of death) and can be expanded to accommodate the unique needs of the SUDORS data collection.

### **SUDORS coordination with vital statistics**

Even though the National Vital Statistics System (NVSS) collects information on drug overdose deaths via death certificates, this information differs from SUDORS. Death certificate data focuses on when and why deaths occurred but does not provide information on risk factors for the overdose such as recent release from an institution or mental health history or on all the specific drugs detected in the decedent which can inform tailoring of interventions. In contrast, by reviewing the full ME/C report, SUDORS provides more comprehensive drug use histories of decedents and tracks the immediate circumstances around the drug overdose death such as whether a bystander was present or whether the decedent was recently released from an institution. Additionally, SUDORS collects data from toxicology reports that provide the most complete view of drugs contributing to the overdose death as well as other drugs present. This can help identify both drugs contributing to overdoses as well as drug use patterns potentially associated with a high number of overdose deaths (i.e., what drugs are people experiencing a fatal overdose using and can this drug use pattern be targeted for intervention).

The Division of Overdose Prevention (DOP), CDC is collaborating with the National Center for Health Statistics (NCHS), CDC to streamline and improve the quality and timeliness of drug overdose data collected on the death certificate as outlined in the previous NOA terms of clearance for SUDORS. These improvements may indirectly improve SUDORS, which contains information abstracted from the death certificate. Also, one of the collaborations supporting interoperability among ME/C case management systems, state vital statistics, and state surveillance systems may directly enhance SUDORS reporting in some states.

In accordance with OMB's terms of clearance, CDC-NCIPC continues to collaborate with NCHS to share knowledge and optimize investments associated with collecting data from medical examiners and coroners. A summary of collaborations since the last OMB submission is summarized in the provided attachment (See Attachment G).

Future collaborative priorities for NCHS and NCIPC/DOP will be driven by lessons learned from the above activities.

**Coordination between Drug Overdose Surveillance Epidemiology (DOSE) and SUDORS**  
Also funded in 49 states and the District of Columbia by the Overdose Data to Action in States

(OD2A-States, CDC-RFA-CE-23-0002) notice of funding opportunity (NOFO), the Drug Overdose Surveillance and Epidemiology (DOSE) system is designed to provide situational awareness of changes in nonfatal drug overdoses, including identifying drug overdose outbreaks, by conducting monthly surveillance of emergency department (ED) visits involving suspected drug, opioid, heroin and stimulant overdoses at the local, state, and regional level. SUDORS and DOSE complement each other. Specifically, SUDORS collects the following unique information not captured by DOSE:

- 1) SUDORS collects data on fatal drug overdoses while DOSE collects information on nonfatal overdoses treated in EDs. While often similar, trends in nonfatal overdoses may differ from fatal overdoses for reasons including the expanded distribution of naloxone (an antidote to opioid overdose) to both first responders and lay people that may decrease the percent of opioid overdoses that are fatal<sup>24</sup> and the possibilities of the fatal overdoses occurring before medical treatment is possible due to no one witnessing the overdose<sup>25</sup> or the rapid progression of overdoses involving fentanyl and fentanyl analogs.<sup>26</sup>
- 2) SUDORS collects in-depth information on drug overdose deaths including forensic toxicology findings and circumstances of overdose, while DOSE focuses on tracking changes in the incidence of drug overdoses. Thus, SUDORS provides in-depth information on drugs contributing or present in drug overdoses as well as circumstances of overdoses (e.g., recent relapse or recent release from prison) not available in DOSE.

## **5. Impact on Small Businesses or Other Small Entities**

This study does not impact small businesses or other small entities

## **6. Consequences of Collecting the Information Less Frequently**

The continued increases in drug overdose deaths, coupled with the rapidly evolving drug supply, highlight the need for timely data collection to support ongoing national, state, and local efforts to reduce drug-related morbidity and mortality. The current system is striving to collect data with a 7-month time lag from the end of a given reporting period (e.g., complete data collection on drug overdose deaths occurring from January to June 2025 by January 2026).

If SUDORS information is not collected, consistent in-depth information on the circumstances related to unintentional and undetermined intent drug overdose deaths will not be available and this will inhibit tailoring of prevention efforts. Delays in data collection would impede the ability of the SUDORS program to obtain more rapid mortality data that can inform deployment of prevention and intervention strategies to address the ongoing drug overdose epidemic and be responsive to the congressional intent of the program funding.

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

This data collection complies fully with the guidelines in 5CFR 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 30<sup>th</sup> 2025. Volume 90, Number 187, pp 46888 (Attachment B). CDC received fifteen comments of which two were anonymous, 4 substantive and 9 -non substantive. (Attachment B1).

**B. Efforts to Consult Outside the Agency**

NCIPC currently collaborates with 49 states and the District of Columbia on the SUDORS data collection through the Overdose Data to Action in States collaborative agreement. As part of OD2A, a SUDORS workgroup, which comprises data abstractors and epidemiologists from the 50 health departments participating in SUDORS as well as CDC staff, has met monthly to discuss ways of improving the quality of data and identifying new data elements to include in SUDORS that can enhance the public health impact of SUDORS. Many of the changes to the NVDRS web system submitted as part of the previous OMB revision were informed or initiated in response to feedback from health departments participating in the SUDORS workgroup. In addition, NCIPC collaborates with the National Association of Medical Examiners and Coroners and the International Association of Coroners and Medical Examiners through IPAs and cooperative agreements with the Association of State and Territorial Health Officials and the Public Health Institutes to provide feedback on SUDORS data elements and data interpretation. The current project also builds on the work performed and external consultation performed by NVDRS when the NVDRS web-system was designed.

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

No incentives, payments or gifts will be provided to survey participants

**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. SUDORS is housed within the NVDRS web-based system. The NVDRS system has a current Authorization to Operate. The Privacy Impact Assessment (PIA) is attached (Attachment F).

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

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. Data from all participating health departments (i.e., states and the District of Columbia) will be entered in the NVDRS web-based platform maintained by CDC. Data will be continuously transmitted via the web to a secure CDC-based server. The data collection will integrate the same validation and security measures implemented by NVDRS. Also, CDC will provide state project personnel coding training to help increase data quality.

CDC and the participating health departments will conduct analyses of the data. This is secondary data and is dependent on separate data collection efforts in each state managed by the state health departments or their bona fide agent. Data from all states will be entered in the NVDRS web-based platform maintained by CDC. Participating health departments will only enter de-identified information. Thus, the proposed data collection will have little or no effect on the respondent's privacy.

To ensure security of the data, several procedures will be implemented:

- Data are maintained securely throughout the data collection and data processing phases.
- Data are stored on a secure CDC-based server accessed via a secure web platform. Authorized public health users only will be able to download de-identified datasets from their jurisdiction (e.g., Washington state SUDORS staff can only access data on deaths in Washington).
- Supplemental data (i.e., any information not included in the web-based system) collected by participating health departments such as paper abstraction worksheets or additional information collected on drug overdose deaths will be stored at the state, district or territorial level in secured computers that reside within the local health department's firewalls. Such information will never be sent from the local health department to the CDC or to a CDC contractor.
- The CDC web system does not store personal identifying information such as names, address, SSN, or date of birth.
- SUDORS suppresses data of 9 or fewer deaths if data are stratified in such a way that an individual could potentially be identified and information about the death could be made known (e.g., if presenting circumstance information about 1 death in a specific state by sex and race); otherwise data are not suppressed.
- Only authorized CDC staff working on the SUDORS team have access to the de-identified web-based data.

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

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 needed. Human participants will not be used (Attachment C).

No sensitive questions are asked directly to witnesses of fatal unintentional or undetermined intent drug overdose or their next of kin. Information on sensitive issues, e.g., mental illness and substance misuse or substance use disorder, has already been collected by state and local ME/C agencies through the death scene investigation process. SUDORS is funding states to abstract and record this information (i.e., conduct an analysis of secondary data) in a standardized format to enhance comparability and facilitate analysis.

## **12. A. Estimates of Annualized Burden Hours and Costs**

There are no standard paper data collection forms to be used by local health departments because

they will be abstracting information from electronic or paper vital statistics or ME/C records into the CDC web-based data system. Burden was estimated through SUDORS experience working with 47 health departments and the District of Columbia as well as NVDRS burden estimates. NVDRS has approximately 15 years of experience working with health departments to collect similar data on violent deaths to inform its estimates of annualized burden hours and costs.

The burden was estimated as follows:

1. The burden estimates are based on unintentional and undetermined intent drug overdose deaths that occurred among all 50 states in 2020, or 87,302 deaths. The total number of unintentional or undetermined intent drug overdose deaths per jurisdiction was estimated by dividing the total number of drug overdose deaths, 87,302, by the number of participating health departments, 51, or approximately 1,711 deaths per participating health department.
2. To develop the burden estimates per participating health department, we estimated that for each death vital statistics would require about 0.25 hours to retrieve, refile, and provide death certificate data to SUDORS. Similarly, ME/C agencies would require 0.25 hours per death to retrieve, refile, and provide ME/C reports to SUDORS. Summing the burden across vital statistics and ME/C agencies results in a burden of about 0.5 hours, or 30 minutes per death. Expanded use of electronic vital statistics and ME/C systems should reduce this burden over time.
  - a. The ME/C and vital statistics burden excludes abstracting data elements from the retrieved files because abstraction is completed by the local public health department staff or contractors who are funded by CDC to complete this task.
  - b. SUDORS' burden estimates exclude state, district or territorial staff time spent abstracting data because these abstractors are funded by CDC to do this work.

#### Estimated Annualized Respondent Burden Hours

Type of Respondent	Form Name	No. of Respondents	Total No. of Responses per Respondent	Average Burden per Response (In hours)	Total Burden Hours (In hours)
Public Agencies	Retrieving and refiling records_SUDORS Screenshots (Att. E)	51	1,711	30/60	43,631
Total					43,631

#### 12. B. Estimated Annualized Respondent Burden Costs:

The staff who are retrieving records will vary substantially across organizations because administrative staff may pull records in large ME/C or vital statistics offices while in some smaller counties elected coroners may pull records. 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 (\$29.87) as estimated by the Bureau of Labor Statistics (<https://www.bls.gov/oes/current/999001.htm#00-0000>, accessed on March 21, 2022)

was used to estimate burden costs.

**Estimated Annualized Respondent Burden Costs**

Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (In hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Cost
Public Agencies	51	1,711	30/60	43,631	\$29.87	\$1,303,258
<b>Total</b>						<b>\$1,303,258</b>

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

There is no record keeping 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
Contract for maintenance and improvements of the data collection software	\$500,000
Contracts and cooperative agreements with national data partners to assist SUDORS in collecting data from ME/C agencies, creating SUDORS data collection standards and creating data collection guidance, and providing technical assistance to CDC as well as state and local health departments on data collection (e.g., National Association of Medical Examiners (NAME), International Association of Coroners and Medical Examiners (IAC&ME), Council of State and Territorial Epidemiologist (CSTE) and Association of State and Territorial Health Officials (ASTHO))*	\$500,000
<b>Total Estimated Contract Costs</b>	<b>\$1,000,000</b>

Government costs

Personnel	Tasks	Avg. cost/yr.
2 Senior scientists (75%)	Program oversight and strategic direction	\$255,000
6 Epidemiologists (75%)	• Direct technical assistance to 50 health departments participating in	\$490,000

	<p>SUDORS.</p> <ul style="list-style-type: none"> <li>• Responsible for data quality checking across funded jurisdictions</li> <li>• Work to enhance SUDORS data quality and guidance.</li> <li>• Conduct surveillance using SUDORS data</li> <li>• Disseminate SUDORS data</li> <li>• Manage and improve the receipt, cleaning, validation, and standardized analysis of SUDORS data.</li> </ul>	
15 Public health advisors (5%)	Programmatic, budgetary, administrative management and oversight of SUDORS as part of OD2A NOFO	\$78,000
Indirect staff costs		\$246,900
<b>Total</b>		<b>\$1,069,900</b>

## 15. Explanation for Program Changes or Adjustments

This request has the following minor revisions: 1) implement updates to the web-based system to improve performance, functionality, and accessibility; and 2) add new data elements to the system. These revisions do not affect the burden estimates.

The updates to the web-based system are as follows:

- Software Enhancements: While not involving any changes to data elements collected, software enhancements have improved functionality in the Toxicology module of the system, record validation, and data import.
- Dashboard modifications: The Victim Data Quality report was updated to reflect revised standards for timely initiation of SUDORS cases. In addition, it shows data of victims with circumstances from multiple data sources to better reflect the standard for inclusion in the national dataset.
- Bulk record validation: this function generates error reports on demand for incidents that do not meet SUDORS quality standards. It gathers all the error, warning, and quality messages together into a single CSV formatted text file that can be opened in Excel or any number of programs.
- Toxicology modifications: To give programs better control over the ordering of substances entered on the Toxicology Findings, a function was added to allow users to move substances up and down. This makes it easier for programs to ensure substances are entered in the same order as they appear on a toxicology report.

The new data elements added to the system as part of a web-based system software update

(version 2.7) are as follows:

- Changes to Race and Ethnicity Data Elements: To bring SUDORS into alignment with the U.S. Standard Certificate of Death developed by the National Center for Health Statistics ([NVSS - Revisions of the U.S. Standard Certificates and Reports](#)), detailed sub-categories have been added to the “Asian” and “Native Hawaiian or Other Pacific Islander” categories. The Asian category will now include: Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and Other Asian. The Native Hawaiian or Other Pacific Islander category will now include: Native Hawaiian, Guamanian or Chamorro, Samoan, and Other Pacific Islander. There are plans to make necessary revisions to the data elements to comply with the *Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity* (SPD 15) by March 28, 2029;
- Place of Death: In addition to the state of death, which has been collected from the start of the NVDRS, the County of Death has been added;
- Changes to Mental Health and Substance Abuse Data Elements: Data elements that have grouped mental health and substance abuse treatments together have been expanded to distinguish the two. “Current mental health/substance abuse treatment” was expanded with two child elements, “Current treatment for mental health problem” and “Current treatment for substance use/misuse problem.” Similar expansions were made to the elements “Ever treated for mental health or substance abuse problem” and “Non-adherence to mental health/substance abuse treatment.”
- Data elements have been added to the OD (“Overdose”) tab to better collect information about circumstances surrounding overdose deaths that previously were captured in text-based incident narratives.
- Creation of a new Rapid Reporting Feature: This feature is in development. All of these aforementioned modifications to system software are detailed with screen captures in Attachment E.

Two changes were approved in a change request in March 2025:

- Removal of a check-box data element that previously was used to document transgender status of decedents
- Removal of a response option (“X”) for the “sex” data element

## **16. Plans for Tabulation and Publication and Project Time Schedule**

Data aggregated across states will be presented in tabulations of outcomes such as overdose deaths involving illegal versus prescription drugs and identification of opportunities for the prevention drug overdose deaths (See **Drug Overdose Deaths Involving Stimulants — United States, January 2018–June 2024** for an example).<sup>27</sup> These will be released in CDC publications such as *MMWR* or in other peer-reviewed publications. Although health departments participating in SUDORS will still report data to CDC twice a year, a key goal is to increase the number of jurisdictions that are able to meet reporting requirements with sufficiently complete data. CDC will continue to work with these health departments to improve data timeliness and quality and secure the participation of the 1 remaining state health department that does not participate in SUDORS.

## Time Schedule

Task	Time Period
Collection and Preliminary analysis files, including counts of unintentional drug overdose based on vital statistics and ME/C reports	7 - 36 months
Final analysis files prepared	12 months
Public release through web-based interface or surveillance report/data brief/publication	18 months

Initial reports will include crude rates for unintentional and undetermined intent drug overdose deaths, overdose deaths related to opioid pain relievers (OPR), and overdose deaths related to illegal drugs (e.g., heroin and illegally-manufactured fentanyl) by state or district. Sex, race, and age-specific rates will be presented as well as preliminary toxicology findings. Toxicology analyses will focus on specific drugs commonly contributing to drug overdose deaths, emerging threats such as nitazene analogs and fentanyl analogs, and fentanyl adulterants such as xylazine and medetomidine. Final analyses will include description of drugs contributing to overdose deaths and description of key circumstances (e.g., a history of substance misuse and route of administration). In depth analyses of how risk factors vary by county and county characteristics will also be conducted. In later years, time trends will be shown.

No sophisticated statistical techniques such as statistical weighting will be required to display these surveillance data because all unintentional and undetermined intent drug overdose deaths in a jurisdiction are collected (i.e., this is a census of unintentional and undetermined intent drug overdose deaths). A few states have chosen to implement SUDORS by abstracting death certificate data for all unintentional and undetermined intent drug overdose deaths in the state and abstracting ME/C data for all unintentional and undetermined intent drug overdose deaths that occurred in a subset of their counties that account for greater than 75% of unintentional or undetermined drug overdose deaths occurring in their state. CDC will continue to work with these states to collect all drug overdose deaths occurring in their state. This subset option was created based on feedback from large states such as California that argued multiple years were needed to establish SUDORS in large states with high numbers of UUDO deaths.

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

The OMB expiration date will be displayed on the opening screen of the NVDRS/SUDORS web-based software.

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

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

<sup>1</sup> Garnett MF, Miniño AM. Drug overdose deaths in the United States, 2003–2023. NCHS Data Brief, no 522. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: <https://dx.doi.org/10.15620/cdc/170565>

<sup>2</sup> Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2025. DOI: <https://dx.doi.org/10.15620/cdc/20250305008>

<sup>3</sup> Additional information on President Trump’s Initiative to Stop Opioid Abuse, <https://www.whitehouse.gov/opioids/>

<sup>4</sup> [Secretary Kennedy Renews Public Health Emergency Declaration to Address National Opioid Crisis | HHS.gov](https://www.hhs.gov/secretary-kennedy-renews-public-health-emergency-declaration-to-address-national-opioid-crisis)

<sup>5</sup> [2025-Trump-Administration-Drug-Policy-Priorities.pdf](https://www.hhs.gov/2025-trump-administration-drug-policy-priorities.pdf)

<sup>6</sup> Tanz LJ, Stewart A, Gladden RM, Ko JY, Owens L, O’Donnell J. Detection of Illegally Manufactured Fentanyl and Carfentanil in Drug Overdose Deaths — United States, 2021–2024. MMWR Morb Mortal Wkly Rep 2024;73:1099–1105. DOI: <http://dx.doi.org/10.15585/mmwr.mm7348a2>

<sup>7</sup> [SUDORS Dashboard: Fatal Drug Overdose Data | Overdose Prevention | CDC](https://www.cdc.gov/sudors/)

<sup>8</sup> Tanz LJ, Miller KD, Dinwiddie AT, et al. Drug Overdose Deaths Involving Stimulants — United States, January 2018–June 2024. MMWR Morb Mortal Wkly Rep 2025;74:491–499. DOI: <http://dx.doi.org/10.15585/mmwr.mm7432a1>

<sup>9</sup> Roberts A, Korona-Bailey J, Mukhopadhyay S. *Notes from the Field*: Nitazene-Related Deaths — Tennessee, 2019–2021. MMWR Morb Mortal Wkly Rep 2022;71:1196–1197. DOI: <http://dx.doi.org/10.15585/mmwr.mm7137a5>

<sup>10</sup> Nham A, Le JN, Thomas SA, et al. Overdoses Involving Medetomidine Mixed with Opioids — Chicago, Illinois, May 2024. MMWR Morb Mortal Wkly Rep 2025;74:258–265. DOI: <http://dx.doi.org/10.15585/mmwr.mm7415a1>

<sup>11</sup> [Lifesaving Naloxone | Stop Overdose | CDC](https://www.cdc.gov/lifesaving-naloxone/)

<sup>12</sup> [Opioid Use Disorder: Treating | Overdose Prevention | CDC](https://www.cdc.gov/opioid-use-disorder/)

<sup>13</sup> Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: <http://dx.doi.org/10.15585/mmwr.rr7103a1>

<sup>14</sup> [Over 115 million pills containing illicit fentanyl seized by law enforcement in 2023 | National Institute on Drug Abuse \(NIDA\)](https://www.nida.nih.gov/2023/07/over-115-million-pills-containing-illicit-fentanyl-seized-by-law-enforcement-in-2023)

<sup>15</sup> Tanz LJ, Gladden RM, Dinwiddie AT, et al. Routes of Drug Use Among Drug Overdose Deaths — United States, 2020–2022. MMWR Morb Mortal Wkly Rep 2024;73:124–130. DOI: <http://dx.doi.org/10.15585/mmwr.mm7306a2>

<sup>16</sup> Tanz LJ, Miller KD, Dinwiddie AT, et al. Drug Overdose Deaths Involving Stimulants — United States, January 2018–June 2024. MMWR Morb Mortal Wkly Rep 2025;74:491–499. DOI: <http://dx.doi.org/10.15585/mmwr.mm7432a1>

<sup>17</sup> Tanz LJ, Stewart A, Gladden RM, Ko JY, Owens L, O’Donnell J. Detection of Illegally Manufactured Fentanyl and Carfentanil in Drug Overdose Deaths — United States, 2021–2024. MMWR Morb Mortal Wkly Rep 2024;73:1099–1105. DOI: <http://dx.doi.org/10.15585/mmwr.mm7348a2>

<sup>18</sup> Vivolo-Kantor AM, Mattson CL, Zlotorzynska M. *Notes from the Field*: Ketamine Detection and Involvement in Drug Overdose Deaths — United States, July 2019–June 2023. MMWR Morb Mortal Wkly Rep 2024;73:1010–1012. DOI: <http://dx.doi.org/10.15585/mmwr.mm7344a4>

<sup>19</sup> Dinwiddie AT, Gupta S, Mattson CL, O’Donnell J, Seth P. Reported Non–Substance-Related Mental Health Disorders Among Persons Who Died of Drug Overdose — United States, 2022. MMWR Morb Mortal Wkly Rep 2024;73:747–753. DOI: <http://dx.doi.org/10.15585/mmwr.mm7334a3>

<sup>20</sup> Tanz LJ, Gladden RM, Dinwiddie AT, et al. Routes of Drug Use Among Drug Overdose Deaths — United States, 2020–2022. MMWR Morb Mortal Wkly Rep 2024;73:124–130. DOI: <http://dx.doi.org/10.15585/mmwr.mm7306a2>

<sup>21</sup> O’Donnell J, Tanz LJ, Miller KD, et al. Drug Overdose Deaths with Evidence of Counterfeit Pill Use — United States, July 2019–December 2021. MMWR Morb Mortal Wkly Rep 2023;72:949–956. DOI: <http://dx.doi.org/10.15585/mmwr.mm7235a3>

<sup>22</sup> Kariisa M, O’Donnell J, Kumar S, Mattson CL, Goldberger BA. Illicitly Manufactured Fentanyl–Involved Overdose Deaths with Detected Xylazine — United States, January 2019–June 2022. MMWR Morb Mortal Wkly Rep 2023;72:721–727. DOI: <http://dx.doi.org/10.15585/mmwr.mm7226a4>

<sup>23</sup> Tanz LJ, Dinwiddie AT, Mattson CL, O’Donnell J, Davis NL. Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021. MMWR Morb Mortal Wkly Rep 2022;71:1576–1582. DOI: <http://dx.doi.org/10.15585/mmwr.mm7150a2>

<sup>24</sup> Guy GP Jr., Haegerich TM, Evans ME, Losby JL, Young R, Jones CM. Vital Signs: Pharmacy-Based Naloxone Dispensing — United States, 2012–2018. MMWR Morb Mortal Wkly Rep 2019;68:679–686. DOI: <http://dx.doi.org/10.15585/mmwr.mm6831e1>

<sup>25</sup> Mattson, C.L., et al. (2018). “Opportunities to Prevent Overdose Deaths Involving Prescription and Illicit Opioids, 11 States, July 2016–June 2017”. *Morbidity and Mortality Weekly Report* 67(34):945–951. DOI: <http://dx.doi.org/10.15585/mmwr.mm6734a2>.

<sup>26</sup> O’Donnell JK, et al. (2017). “Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700 — 10 States, July–December 2016”. *Morbidity and Mortality Weekly Report* 66(43):1197–1202. DOI: <http://dx.doi.org/10.15585/mmwr.mm6643e1>.

<sup>27</sup> Tanz LJ, Miller KD, Dinwiddie AT, et al. Drug Overdose Deaths Involving Stimulants — United States, January 2018–June 2024. MMWR Morb Mortal Wkly Rep 2025;74:491–499. DOI: <http://dx.doi.org/10.15585/mmwr.mm7432a1>