

SUPPORTING STATEMENT: PART A

February 6, 2026

Advancing Violence Epidemiology in Real-Time (AVERT)

Renewal

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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 violence-related injuries and mental health conditions to CDC.

Intended use of the resulting data: To improve local, state, and regional situational awareness of trends in violence-related injuries and mental health conditions to inform 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 85% of ED visits in the United States.

The subpopulation to be studied: Individuals who visit an ED to receive treatment for violence-related injuries and mental health conditions.

How data will be analyzed: Descriptive analyses (e.g., frequencies and changes in the rate of ED visits involving violence-related injuries, and 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 as a renewal of previously approved information collection. This request is for continued approval to collect information for AVERT using the existing data collection approach, case definitions, and National Syndromic Surveillance Program (NSSP) infrastructure. 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

AVERT supports data collection efforts that expand and enhances partnerships with public health departments initiated to share emergency department (ED) visit data with CDC. The AVERT program provides funding to 12 jurisdictions (11 state health departments and the District of Columbia health department) to conduct routine monitoring of ED visits related to

violence-related injuries and mental health conditions, and to analyze these data in a timely manner and share these data with CDC to support public health surveillance and response. AVERT also ensures that 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 violence and mental health related ED visits.

AVERT leverages existing ED data collection efforts deployed across state health departments through CDC's National ED Syndromic Surveillance program. The Office of Public Health Data, Surveillance, and Technology (OPHDST) 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 85% of ED facilities in the US (>7,500 participating EDs). Key strengths of AVERT's existing approach include:

1. AVERT leverages ED data already collected by state and local health departments, supporting continued operation with minimal burden and providing a scalable approach that can be expanded to additional jurisdictions, including at a national level.
2. AVERT builds on existing CDC infrastructure, avoiding duplication and supporting efficient sharing and analyses of ED data between jurisdictions and CDC.
3. AVERT maintains active involvement of state and local health departments in the collection, ownership and use of the ED data. These jurisdictions play a central role in leading surveillance activities using ED visit data, responding to local changes in violence-related ED visits, identifying data quality issues and contributing to the development of surveillance 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 all types of violence-related injuries, suspected child abuse and neglect, and mental health conditions (**Attachment D**).

AVERT supports ongoing federal efforts to modernize public health data systems by leveraging near real-time electronic health data to improve the timeliness, completeness, and usability of surveillance information. By utilizing existing syndromic surveillance infrastructure and standardized analytic definitions, AVERT enhances the ability of public health agencies to rapidly detect emerging trends, monitor population-level health outcomes, and inform timely, data-driven decision-making.

A.2. Purpose and Use of Information Collection

AVERT operates in 12 jurisdictions (11state health departments and the District of Columbia health department) funded from September 2023 through August 2028, through which a competitive process was undertaken to select the recipients. AVERT will continue to establish and maintain local and state information collection of 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. All 12 of these jurisdictions provide CDC access to their syndromic surveillance data from EDs in CDC's NSSP system. Health departments have used this data to populate state data dashboards 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 violence-related injuries in their communities.

Participating jurisdictions sharing syndromic surveillance data with CDC will be required to review, validate, and submit the *ED Violence Data Form (Attachment E)* on a bimonthly basis. Emergency departments routinely submit visit data to state and local health departments as part of syndromic surveillance. Participating jurisdictions already share these data with CDC through the existing NSSP BioSense Platform under the NSSP information collection (OMB #0920-0824). CDC uses these existing data to pre-populate the *ED Violence Data Form*. Participating jurisdictions review the information for accuracy, provide metadata that are not available through NSSP, validate the report, and submit the finalized aggregate report to CDC. The justification for the data elements collected through the *ED Violence Data Form* is described 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 are described in Table 1 below.

Table 1. Justification for sharing key variables with CDC

Variable	Justification for collecting
Count of ED visits related to violence-related injuries	• Detect and respond to upticks or shifts in violence-related injury trends in a timely manner. • 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, firearm violence 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 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 violence-related injury and mental health indicators	• Aggregating data on 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 violence-related 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 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.

Syndromic surveillance data from emergency departments have been used by jurisdictions to monitor and communicate timely trends in violence related injuries and other health outcomes. These data have supported situational awareness and public health response including identifying changes in injury patterns during the COVID-19 pandemic and other emergent events. Data collected through AVERT will further support these efforts by enabling jurisdictions to conduct near real time monitoring of violence related ED visits, apply standardized definitions and disseminate findings through data dashboards, reports, and other public facing products.

Example publications

1. Zwald ML, Chen Y, Swedo E. et al. (2025). Trends in violence-related emergency department visits among children and adolescents <18 years in 12 jurisdictions, January 2022-April 2025. DOI: <https://doi.org/10.1136/ip-2025-046018>
2. Zwald ML, Chen Y, Holland. et al. (2025). Trends in Mental Health-Related Emergency Department Visits in 12 U.S. Jurisdictions, 2022 to 2024. DOI: <https://doi.org/10.1016/j.annemergmed.2025.10.026>
3. Holland KM, Chen Y, Zwald ML, et al. Notes from the Field: Trends in Emergency Department Visits for Firearm Injuries — United States, January 2018–December 2023. MMWR Morb Mortal Wkly Rep 2024;73:1064–1066. DOI: <http://dx.doi.org/10.15585/mmwr.mm7346a4>

4. 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. DOI: <http://dx.doi.org/10.15585/mmwr.mm7127a1>.
5. 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. DOI: <http://dx.doi.org/10.15585/mmwr.mm7108e1>.
6. 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.. 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. This approach supports broader public health data modernization efforts by leveraging existing electronic data systems to streamline data collection, improve efficiency, and minimize reporting burden.

1. **Use of existing national surveillance infrastructure.** Emergency department (ED) data are already shared with CDC through the National Syndromic Surveillance Program (NSSP) BioSense Platform, which receives data from more than 7,500 hospitals and captures 85% of ED visits in the United States. Since 2016, NSSP data have been processed and analyzed using the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) (OMB #0920-0824).

AVERT will continue to leverage this existing infrastructure by accessing ED data directly within the NSSP BioSense Platform using ESSENCE. CDC AVERT staff will use existing NSSP data to abstract and analyze data on a bimonthly basis to complete the *ED Violence Data Form*. Participating health departments will review the CDC generated reports for accuracy and provide limited metadata, validate pre-populated data, and submit the finalized form to CDC. Because CDC completes the majority of the form using existing NSSP data, participating jurisdictions are not required to generate reports or conduct routine tabulations, substantially reducing reporting burden.

Additional efficiencies include:

- a. Ongoing enhancements to NSSP BioSense Platform and ESSENCE that improve data sharing, processing and analytic capabilities, which AVERT will continue to leverage.
- b. Collaboration between AVERT, NSSP BioSense, and NCIPC Office of Informatics to better automate analysis of 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.
- c. Availability of standardized AVERT definitions (**Attachment D**) within NSSP BioSense Platform, enabling participating jurisdictions to monitor trends in their local ED data in near-real time.

2. **Standardized data collection tools.** AVERT requires participating health departments to submit data using a standardized *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. **Secure centralized data submission.** 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). This platform reduces burden and improves efficiency by:
 - a. Automatically identifying data submission errors in real time, allowing for rapid correction and reducing the need for multiple submissions.
 - b. Leveraging an established widely used secure system, the NCIPC Partner's Portal provides centralized access to external users (e.g., state and local health departments) to CDC operated data and computer applications. This approach minimizes onboarding time and training requirements for participating jurisdictions.

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

AVERT maximizes the use of existing federal data systems by leveraging ED data already collected by the NSSP BioSense Platform (described in *A1. Circumstances Making the Collection of Information Necessary*) and by maintaining ongoing coordination with other federal ED data collections. CDC's Division of Violence Prevention (DVP) is engaged in an intensive collaboration with the DHIS, the CDC division that operates NSSP BioSense Platform. The collaboration enhances rapid surveillance of violence-related injuries and mental health conditions by leveraging the approximately 85% of ED facilities in the U.S. 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. This approach minimizes reporting burden by enabling CDC to conduct centralized data extraction and analysis to complete the *ED violence data form*, while allowing health departments to focus on data validation and contextual interpretation. It also improves data quality through ongoing collaboration between CDC and participating jurisdictions.

As specified in the 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 and assessed 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

ED data system	Description	Time lag	Purpose of ED system	Additional Value of AVERT
				comprehensive regional and national situational awareness of violence trends as more states will publicly report 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 system is no longer collecting data as of 2024)	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 communicates on an ongoing basis with other federal ED data collections to avoid duplication and identify opportunities for collaboration. These efforts include comparing AVERT findings with HCUP, SEDS, and FISS findings in similar geographic areas or hospitals. Such comparisons help inform revisions and improvements in AVERT’s syndrome definitions of ED visits involving 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 and the District of Columbia health departments 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:

- **Reduced timelines of situational awareness and response.** Federal and state governmental situational awareness of trends in violence- and mental health-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.

- **Delayed public awareness and action.** Public situational awareness on changes in 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 violence-related injuries and mental health conditions. The National Center for Health Statistics publishes provisional death data on violence-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).
- **Diminished local surveillance and data quality.** Less frequent data collection would reduce the ability of local health departments to monitor how trends in their jurisdictions compare with state and regional patterns in a timely manner. This delay would limit situational awareness and hinder timely local surveillance and response to violence-related injuries and mental health conditions. In addition, AVERT reporting includes ongoing data quality review and feedback. 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 requires bimonthly reporting of aggregate ED data on 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 May 27, 2026 vol. 91 No. 101, pp. 31458 (**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 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 OPHDST, 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 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 one data form:

ED violence data form (**Attachment E**) supports rapid bimonthly ED surveillance of 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 violence-related injuries, suspected child abuse and neglect 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 violence-related injuries, 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 0.25 hours per bimonthly report per jurisdiction. Thus, the annual burden per health department will be 1.5 hours (0.25 hours x 6 months) or a total of 18 burden hours across the 12 responding health departments (Table 3).

Table 3. Estimates of annualized respondent burden hours

Type of respondent	Form name	Number of respondents	Total number of responses per respondent	Average burden per response (in hours)	Total annual burden (in hours)

			(Annual #)		
Participating health departments sharing case-level ED data with CDC through the NSSP BioSense (OMB #0920-0824)*	ED form (<i>ED violence data form</i>) Attachment E	12	6	15/60	18
Total					18

* 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 Life, Physical and Social Science occupations (\$47.06) is based on similar mid to high level epidemiologist positions according to the May 2025 Occupational Employment and Wage Statistics from the U.S. Bureau of Labor Statistics https://www.bls.gov/web/empsit/ceseeb8a.htm#ce_ee_table8a.f.2 (the most recent data available, accessed on 08/06/2026). This was used to estimate the annualized respondent burden costs below (Table 4).

Table 4. Estimates of annualized respondent burden costs

Type of respondents	Form Name	Total burden (in hours)	Hourly wage rate	Total respondent cost	Wage rate multiplier	Fully loaded Cost Burden
State and DC health departments sharing case-level ED data with CDC through the NSSP BioSense (OMB #0920-0824)*	ED Violence Data form	18	\$47.06	\$847.08	x2	\$1694.16
Average Per Year						\$1694.16

* 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

This data collection will not result in costs for respondents or record keepers. No capital, maintenance, start-up, hardware, or software costs are expected for respondents or record keepers.

A.14. Annualized Cost to the Government The average annualized cost to the federal government is **\$629,284** with a fully loaded cost of **\$ 1,258,568**. CDC personnel costs follow the General Schedule ([SALARY TABLE 2026-ATL](#)). HHS currently assumes that benefits plus indirect costs equal approximately 100 percent of wages. In other words, multiplying wages by a factor of 2 provides an estimate of the fully loaded wage rate, as summarized in Table 5.

Table 5. AVERT Government Costs

Type of Cost	Description of Services	Annual Cost	Wage Rate Multiplier	Fully loaded Cost
CDC Personnel	50% of one GS-14 Senior Scientist at \$133,007/year	\$66,504	X2	\$133,008
	100% of one GS-13 Epidemiologist at \$112,556/year	\$112,556	X2	\$225,112
	100% of one GS-13 Data Manager at \$112,556/year	\$112,556	X2	\$225,112
	100% of three GS-13 Public Health Advisors at \$112,556/year	\$112,556 *3=337,668	X2	\$675,336
Total		\$629,284		\$ 1,258,568

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

Adjustments include the following:

- Language throughout was updated to comply with the Executive Orders and CDC Priorities.
- Number of recipients: In Year 1, the AVERT program received additional funding to support a total of 12 jurisdictions (11 state health departments and District of Columbia health department), an increase from 10 (see Table 4).
- Annual burden hours: Through collaboration with NSSP, the AVERT program has developed advanced scripts and standardized data reports. As a result, participating jurisdictions will receive these reports directly and will no longer need to develop their own. This has significantly reduced estimated burden hours by half. (see Table 3).

- AVERT Government Costs: The percentage of CDC personnel time allocated to the project has increased to support the expansion of funded AVERT jurisdictions from 10 to 12. (See Table 5)

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

Monthly, quarterly, and yearly trends in ED visits involving violence-related injuries and mental health conditions (which may increase risk for or be a negative associated with violence-related injuries) will continue to be reported publicly by CDC on an ongoing basis, consistent with the project time schedule below. Additional analyses will continue examining patterns by age group, sex, race/ethnicity, and county and may include comparisons with other data sources, such as violent death data to provide a more comprehensive understanding of trends. Findings will continue to 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 (<i>ED violence data form</i>) 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 visits involving violence-related injuries and mental health conditions will be posted on the web for public access	6 – 12-months from when the ED visit 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 violence-related injuries and mental health conditions	At least two articles per year will be published
Conduct analyses to support improved data collection and analysis	
Conduct ongoing analysis of metadata submitted by jurisdictions to inform improvements to data collection	These activities occur on an ongoing basis, as sufficient data is available.

Future publications will focus on:

- Identifying patterns of ED visits for 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 violence-related injuries and mental health conditions.
- Comparing state and national trends in ED visits involving 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.