TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS

Form name	Number of respondents	Number of responses per respondent (annually)	Total responses	Average burden per response (in hours)	Total burden hours
Rural Communities Opioid Response Program Performance Measures	243	2	486	5.66	2,750
Total	243		486		2,750

Maria G. Button,

Director, Division of the Executive Secretariat.

[FR Doc. 2019–15883 Filed 7–25–19; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

National Advisory Council on Nurse Education and Practice; Meeting Cancellation

AGENCY: Health Resources and Services Administration; Department of Health and Human Services.

ACTION: Notice of meeting cancellation.

SUMMARY: This is to notify the public that the previously scheduled September 24, 2019, meeting of the National Advisory Council on Nurse Education and Practice (NACNEP) is cancelled. This meeting was announced in the **Federal Register**, Vol. 84, No. 45 on Thursday, March 7, 2019 (FR Doc. 2019–04074 Filed 3–6–19). Future meetings will occur in calendar year 2020 and be announced through the **Federal Register** at a later date.

FOR FURTHER INFORMATION CONTACT: Tracy L. Gray, MBA, MS, RN, Chief, Advanced Nursing Education Branch, Designated Federal Officer, NACNEP, 5600 Fishers Lane, Rockville, Maryland 20857, telephone: (301) 945–3113 or email: *BHWNACNEP@hrsa.gov.*

Maria G. Button,

Director, Division of the Executive Secretariat.

[FR Doc. 2019–15894 Filed 7–25–19; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Public Comment Request Information Collection Request Title: Health Resources and Service Administration Uniform Data System, OMB No. 0915–0193—Revision

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: In compliance with the requirement for opportunity for public comment on proposed data collection projects of the Paperwork Reduction Act of 1995, HRSA announces plans to submit an Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting the ICR to OMB, HRSA seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

DATES: Comments on this ICR must be received no later than September 24, 2019.

ADDRESSES: Submit your comments to *paperwork@hrsa.gov* or mail the HRSA Information Collection Clearance Officer, Room 14N136B, 5600 Fishers Lane, Rockville, Maryland 20857.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, email *paperwork@hrsa.gov* or call Lisa Wright-Solomon, HRSA Information Collection Clearance Officer at (301) 443–1984.

SUPPLEMENTARY INFORMATION: When submitting comments or requesting information, please include the ICR title for reference.

Information Collection Request Title: Health Resources and Services Administration Uniform Data System, OMB No. 0915–0193—Revision.

Abstract: The Health Center Program, administered by HRSA, is authorized under section 330 of the Public Health Service (PHS) Act, most recently amended by section 50901(b) of the Bipartisan Budget Act of 2018, Public Law 115–123. Health centers are community-based and patient-directed organizations that deliver affordable, accessible, quality, and cost-effective primary health care services to patients regardless of their ability to pay. Nearly 1,400 health centers operate approximately 12,000 service delivery sites that provide primary health care to more than 27 million people in every U.S. state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. HRSA uses the Uniform Data System (UDS) for annual reporting by certain HRSA award recipients, including Health Center Program awardees (those funded under section 330 of the PHS Act), Health Center Program look-alikes, and Nurse Education, Practice, Quality and Retention (NEPQR) Program awardees (specifically those funded under the practice priority areas of section 831(b) of the PHS Act).

Need and Proposed Use of the Information: HRSA collects UDS data annually to ensure compliance with legislative and regulatory requirements, improve clinical and operational performance, and report overall program accomplishments. These data help to identify trends over time, enabling HRSA to establish or expand targeted programs and to identify effective services and interventions that will improve the health of medically underserved communities. HRSA analyzes UDS data with other national health-related data sets to compare the Health Center Program patient populations and the overall U.S. population.

HRSA plans to continue aligning several clinical measures reported in the UDS with the Centers for Medicare & Medicaid Services' (CMS) electronic specified clinical quality measures (eCQM) and is considering the following changes for 2020 UDS data collection:

- *Retiring CMS126 Use of Appropriate Medications for Asthma:* The CMS eCQM is no longer being

updated when new asthma medications are approved for use. This measure was also retired from the Healthcare Effectiveness Data and Information Set, is no longer endorsed by the National Quality Forum, and there is currently no comparable eCQM for asthma. Thus, no replacement measure is planned at this time.

• *Replacing Dental Sealants for Children Between 6–9 years with CMS74v9 Primary Caries Prevention Intervention as Offered by Primary Care Providers, Including Dentists:* The replacement measure, which is the percentage of children age 0–20 years who received a fluoride varnish application, is applicable to a broader patient population than the use of dental sealants, more applicable to primary care settings by measuring oral health activities that health centers without dentists can employ, and is part of the CMS Merit-based Incentive Payment System quality payment program measure set.

• *Adding CMS159v8 Depression Remission at 12 Months:* The addition of the CMS depression remission measure at 12 months provides complementary mental health outcome data on how well health centers help patients reach remission. Improvement in the symptoms of depression and an ongoing assessment of the current treatment plan is crucial to the reduction of symptoms and psychosocial well-being of patients. The addition of *CMS159v8* further supports HRSA's commitment to HHS strategic objective to ''Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support.''

• *Revising the HIV linkage to care measure:* The HIV linkage to care measure captures the percentage of patients whose first HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first diagnosis. This measure will be modified to change the follow-up treatment from 90 days to 30 days.

• *Adding CMS349v2 HIV Screening:* The addition of the CMS HIV screening measure will contribute to concerted efforts to better identify priority geographies, assist high risk groups among health center patients, and more effectively deploy interventions and resources in support of the ''Ending the HIV Epidemic'' Initiative.

• *Adding Prescription for Pre-Exposure Prophylaxis (PrEP) International Classification of Diseases (ICD) 10 Codes and Current Procedural Terminology (CPT) codes:* The addition of the PrEP ICD–10 and CPT codes will allow for the collection of this HIV prescription prevention data in health centers and further supports the ''Ending the HIV Epidemic'' Initiative.

• *Adding Diabetes Measures: CMS131v8 Diabetes Eye Exam; CMS123v7 Diabetes Foot Exam; and CMS134v8 Diabetes Medical Attention to Nephropathy:* Improving the treatment and management of patients with diabetes is a HRSA priority. Addition of these CMS eCQMs informs HRSA of the breadth of preventive care that patients with diabetes may receive in the health center setting that have profound impact on diabetes-related outcomes and quality of life.

• *Adding CMS125v8 Breast Cancer Screening:* There is substantial geographic and demographic variation in breast cancer death rates, suggesting that there are social and non-economic obstacles that affect breast cancer screening. [i] Preventive screening through timely access to mammograms can lead to early detection, better treatment prognosis, and has the potential to reduce health disparities. [ii]

• *Adding a Prescription Drug Monitoring Programs (PDMPs) Question to Appendix D: Health Center Health Information Technology (HIT) Capabilities:* PDMPs are effective tools for reducing prescription drug abuse and diversion. Improving provider utilization and access to real-time data has demonstrated meaningful results in reducing over-prescribing of medication. [iii]

• *Revising the Social Determinants of Health Question in Appendix E: Other Data Elements:* There is strong evidence that social and economic factors influence an individual's health. [iv]Several health care systems are exploring how to collect information on the social determinants of health. The inclusion of these questions into Appendix E allows HRSA to see how health centers are approaching this challenge and how many of their vulnerable patients are experiencing social and economic risks associated with poor health.

• *Adding ICD–10 Codes to Capture Human Trafficking and Intimate Partner Violence:* HRSA is aware that human trafficking [v] and intimate partner violence [vi] are part of the social determinants of health (SDOH) that can affect a wide range of health and quality of life outcomes. Addressing SDOH is a HRSA objective to improve the health and well-being of health center patients and the broader community in which they reside.

• *Uniform Data System Test Cooperative (UTC):* As part of HRSA's efforts to modernize the UDS we are creating the UTC as an enduring testing and piloting capability. The UTC consists of three main components: A steering committee, a coordinator, and health center test participants. Through this cooperative, HRSA will be able to pilot test innovative information technology and software, streamlining of clinical quality measures, and alternative data collection methodologies to reduce reporting burden and improve data quality and integrity.

Likely Respondents: Likely respondents will include Health Center Program award recipients, Health Center Program look-alikes, and NEPQR Program awardees funded under the practice priority areas of section 831(b) of the PHS Act.

Burden Statement: Burden includes the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install and use technology and systems for the purpose of: Collecting, validating and verifying information, processing and maintaining information, disclosing and providing information. It also accounts for time to train personnel, respond to a collection of information, search data sources, complete and review the collection of information, and transmit or otherwise disclose the information. It will also include testing information necessary to support the UTC. No more than three tests would be conducted each calendar year and no more than 100 health centers would participate in 1 test. Participation is voluntary and will not affect their funding status. This sample size is sufficient to conduct a pilot test and determine if the

[i] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4540479/.*

[ii] *https://www.thecommunityguide.org/findings/cancer-screening-reducing-structural-barriers-clients-breast-cancer.*

[iii] *https://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq.*

[iv] *https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/social-and-economic-factors.*

[v] *https://www.acf.hhs.gov/otip/about/what-is-human-trafficking.*

[vi] *https://www.hrsa.gov/sites/default/files/hrsa/HRSA-strategy-intimate-partner-violence.pdf.*

innovation should be scaled across the Health Center Program. The total annual burden hours estimated for this ICR are summarized in the table below.

TOTAL ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Universal Report	1,471	1	1,471	223	328,033
Grant Report	504	1	504	30	15,120
UTC Tests	100	3	300	80	24,000
Total	2,075		2,275		367,153

HRSA specifically requests comments on: (1) The necessity and feasibility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Maria G. Button,

Director, Division of the Executive Secretariat.

[FR Doc. 2019–15902 Filed 7–25–19; 8:45 a.m.]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

National Vaccine Injury Compensation Program; List of Petitions Received

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: HRSA is publishing this notice of petitions received under the National Vaccine Injury Compensation Program (the Program), as required by the Public Health Service (PHS) Act, as amended. While the Secretary of HHS is named as the respondent in all proceedings brought by the filing of petitions for compensation under the Program, the United States Court of Federal Claims (the Court) is charged by statute with responsibility for considering and acting upon the petitions.

FOR FURTHER INFORMATION CONTACT: For information about requirements for filing petitions, and the Program in general, contact Lisa L. Reyes, Clerk of Court, United States Court of Federal Claims, 717 Madison Place NW, Washington, DC 20005, (202) 357–6400. For information on HRSA's role in the Program, contact the Director, National Vaccine Injury Compensation Program, 5600 Fishers Lane, Room 08N146B, Rockville, Maryland 20857; (301) 443–6593, or visit our website at: *http://www.hrsa.gov/vaccinecompensation/index.html.*

SUPPLEMENTARY INFORMATION: The Program provides a system of no-fault compensation for certain individuals who have been injured by specified childhood vaccines. Subtitle 2 of Title XXI of the PHS Act, 42 U.S.C. 300aa–10 *et seq.,* provides that those seeking compensation are to file a petition with the Court and to serve a copy of the petition to the Secretary of HHS, who is named as the respondent in each proceeding. The Secretary has delegated this responsibility under the Program to HRSA. The Court is directed by statute to appoint special masters who take evidence, conduct hearings as appropriate, and make initial decisions as to eligibility for, and amount of, compensation.

A petition may be filed with respect to injuries, disabilities, illnesses, conditions, and deaths resulting from vaccines described in the Vaccine Injury Table (the Table) set forth at 42 CFR 100.3. This Table lists for each covered childhood vaccine the conditions that may lead to compensation and, for each condition, the time period for occurrence of the first symptom or manifestation of onset or of significant aggravation after vaccine administration. Compensation may also be awarded for conditions not listed in the Table and for conditions that are manifested outside the time periods specified in the Table, but only if the petitioner shows that the condition was caused by one of the listed vaccines.

Section 2112(b)(2) of the PHS Act, 42 U.S.C. 300aa–12(b)(2), requires that ''[w]ithin 30 days after the Secretary receives service of any petition filed under section 2111 the Secretary shall publish notice of such petition in the **Federal Register**.'' Set forth below is a list of petitions received by HRSA on June 1, 2019, through June 30, 2019. This list provides the name of petitioner, city and state of vaccination (if unknown then city and state of person or attorney filing claim), and case number. In cases where the Court has redacted the name of a petitioner and/or the case number, the list reflects such redaction.

Section 2112(b)(2) also provides that the special master ''shall afford all interested persons an opportunity to submit relevant, written information'' relating to the following:

1. The existence of evidence ''that there is not a preponderance of the evidence that the illness, disability, injury, condition, or death described in the petition is due to factors unrelated to the administration of the vaccine described in the petition,'' and

2. Any allegation in a petition that the petitioner either:

a. ''[S]ustained, or had significantly aggravated, any illness, disability, injury, or condition not set forth in the Vaccine Injury Table but which was caused by'' one of the vaccines referred to in the Table, or

b. ''[S]ustained, or had significantly aggravated, any illness, disability, injury, or condition set forth in the Vaccine Injury Table the first symptom or manifestation of the onset or significant aggravation of which did not occur within the time period set forth in the Table but which was caused by a vaccine'' referred to in the Table.

In accordance with Section 2112(b)(2), all interested persons may submit written information relevant to the issues described above in the case of the petitions listed below. Any person choosing to do so should file an original and three (3) copies of the information with the Clerk of the United States Court of Federal Claims at the address listed above (under the heading **FOR FURTHER INFORMATION CONTACT**), with a copy to HRSA addressed to Director, Division of Injury Compensation