The Transparency Act requires the OMB to establish a single searchable database, accessible to the public, with information on financial assistance awards made by Federal agencies. The Transparency Act also includes a requirement for recipients of Federal grants to report information about first-tier subawards and executive compensation under Federal assistance awards.

IHS has implemented a Term of Award into all IHS Standard Terms and Conditions, NoAs and funding announcements regarding the FSRS reporting requirement. This IHS Term of Award is applicable to all IHS grant and cooperative agreements issued on or after October 1, 2010, with a $25,000 subaward obligation dollar threshold met for any specific reporting period. Additionally, all new (discretionary) IHS awards (where the project period is made up of more than one budget period) and where: 1) The project period start date was October 1, 2010 or after and 2) the primary awardee will have a $25,000 subaward obligation dollar threshold during any specific reporting period will be required to address the FSRS reporting. For the full IHS award term implementing this requirement and additional award applicability information, visit the DGM Grants Policy Web site at: *https://www.ihs.gov/dgm/index.cfm?module=dsp_dgm_policy_topics.*

Telecommunication for the hearing impaired is available at: TTY (301) 443–6394.

VII. Agency Contacts

1. Questions on the programmatic issues may be directed to:

Mr. Chris Buchanan, Director, ODSCT, 801 Thompson Avenue, Suite 220, Rockville, Maryland 20852. Telephone: (301) 443–1104. E-Mail: *Chris.Buchanan@ihs.gov.*

2. Questions on grants management and fiscal matters may be directed to:

Mr. John Hoffman, DGM, Grants Management Specialist, 801 Thompson Avenue, TMP Suite 360, Rockville, Maryland 20852. Telephone: (301) 443–2116 Fax: (301) 443–9602. E-Mail: *John.Hoffman@ihs.gov.*

3. Questions on systems matters may be directed to:

Paul Gettys, Grant Systems Coordinator, DGM, 801 Thompson Avenue, TMP Suite 360, Rockville, MD 20852. Phone: 301–443–2114; or the DGM main line 301–443–5204. Fax: 301–443–9602. E-Mail: *Paul.Gettys@ihs.gov.*

VIII. Other Information

The Public Health Service strongly encourages all cooperative agreement and contract recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of the facility) in which regular or routine education, library, day care, health care, or early childhood development services are provided to children. This is consistent with the HHS mission to protect and advance the physical and mental health of the American people.

Dated: March 29, 2015.

Robert G. McSwain,

Acting Director, Indian Health Service.

[FR Doc. 2015–07780 Filed 4–3–15; 8:45 am]

BILLING CODE 4165–16–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Solicitation of Written Comments on the National Vaccine Advisory Committee's Draft Report and Draft Recommendations for Consideration for Addressing the State of Vaccine Confidence in the United States

AGENCY: Office of the Secretary, Office of the Assistant Secretary for Health, National Vaccine Program Office, Department of Health and Human Services

ACTION: Notice.

SUMMARY: The National Vaccine Advisory Committee (NVAC) was established in 1987 to comply with Title XXI of the Public Health Service Act (Pub. L. 99–660) (§ 2105) (42 U.S. Code 300aa–5 (PDF–78 KB)). Its purpose is to advise and make recommendations to the Director of the National Vaccine Program on matters related to program responsibilities. The Assistant Secretary for Health (ASH) has been designated by the Secretary of Health and Human Services (HHS) as the Director of the National Vaccine Program. The National Vaccine Program Office (NVPO) is located within the Office of the Assistant Secretary for Health (OASH), Office of the Secretary, U.S. Department of Health and Human Services (HHS). NVPO provides leadership and fosters collaboration among the various federal agencies involved in vaccine and immunization activities. The NVPO also supports the National Vaccine Advisory Committee (NVAC). The NVAC advises and makes recommendations to the ASH in her capacity as the Director of National Vaccine Program on matters related to vaccine program responsibilities.

Recognizing that immunizations are given across the lifespan and there are likely to be important differences in vaccine acceptance at different stages of life, in February of 2013 the National Vaccine Advisory Committee accepted an initial charge from the Assistant Secretary for Health (ASH) to report on how confidence in vaccines impacts the optimal use of recommended childhood vaccines in the United States, including reaching Healthy People 2020 immunization coverage targets. Focus of such a report may include understanding the determinants of vaccination acceptance among parents, what HHS should be doing to improve parental confidence in vaccine recommendations and how to best measure confidence in vaccine and vaccination to inform and evaluate interventions in the future.

Through a series of teleconferences, electronic communications, presentations and public discussions during the NVAC meetings, a working group identified a number of draft recommendations to further understand and address issues of vaccine confidence in the United States.

On behalf of NVAC, NVPO is soliciting public comment on the draft report and draft recommendations from a variety of stakeholders, including the general public, for consideration by the NVAC as they develop their final recommendations to the ASH. It is anticipated that the draft report and draft recommendations, as revised with consideration given to public comment and stakeholder input, will be presented to the NVAC for adoption in June 2015 at the quarterly NVAC meeting.

DATES: Comments for consideration by the NVAC should be received no later than 5:00 p.m. EDT on May 6, 2015.

ADDRESSES:

(1) The draft report and draft recommendations are available on the Web at *http://www.hhs.gov/nvpo/nvac/subgroups/nvac-vaccine-confidence-wg.html.*

(2) Electronic responses are preferred and may be addressed to: *vcwg@hhs.gov.*

(3) Written responses should be addressed to: National Vaccine Program Office, U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 733G, Washington, DC 20201. Attn: Vaccine Confidence Working Group.

FOR FURTHER INFORMATION CONTACT: National Vaccine Program Office, Office of the Assistant Secretary for Health,

Department of Health and Human Services; telephone (202) 690–5566; fax (202) 690–4631; email: *vcwg@hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Vaccination confidence is one of a number of factors that affect individual and population-level willingness to accept a vaccine. Vaccine confidence means having confidence in the safety and efficacy of a vaccine, having confidence in the competence of the health professionals who administer the vaccine, and having trust in the motivations of the policy-makers who decide which vaccines are needed and when. Vaccine confidence has been shown to influence vaccine decision making, but to what extent remains unclear. This is partly due to a lack of consensus on how best to quantify the confidence of an individual and a population. Gaining this understanding along with identifying factors which drive public confidence is critical for assessing the magnitude of the problem in the U.S., as well as designing and evaluating potential intervention strategies.

Through their analysis and discussion, the NVAC proposes the following recommendations:

Focus Area 1: Measuring and Tracking Vaccine Confidence

1.1 NVAC recommends development of an ''index,'' composed of a number of individual and social dimensions, to measure vaccine confidence. This index should be capable of (1) a rapid, reliable and valid surveillance of national vaccine confidence; (2) detection and identification of variations in vaccine confidence at the community level; and (3) diagnosis of the key dimensions that affect vaccine confidence.

1.2 NVAC recommends continuing the use of existing measures for vaccine confidence, including systems that measure vaccine coverage as well as vaccine-related confidence, attitudes and beliefs while the science of understanding and tracking vaccine confidence is being advanced.

1.3 NVAC recommends the development of measures and methods to analyze the mass media environment and social media conversations to identify topics of concern to parents, healthcare providers, and members of the public.

1.4 NVAC recommends that existing approaches and systems for monitoring vaccination coverages and vaccine-related cognitions, attitudes, and behaviors be strengthened and enhanced. These include: (1) Immunization Information Systems (IIS) and Electronic Health Records (EHRs) to collect and capture delays and refusals; (2) Reliable and valid measures (or surveys) of cognitive factors, such as adults and parents' confidence, attitudes, and beliefs regarding vaccines and recommended vaccinations; (3) Surveys of provider attitudes and beliefs towards vaccination; and (4) Integration of data from all existing systems to track trends of vaccination confidence over time and to detect variations across time and geography.

Focus Area 2: Communication and Community Strategies

2.1 NVAC recommends healthcare providers, immunization programs, and those involved in promoting recommended vaccinations actively reinforce that vaccination according to the Advisory Committee on Immunization Practices (ACIP) recommended schedule is the social norm and not the exception. Misperceptions that vaccination in line with the ACIP recommended schedule is not the norm should be appropriately addressed.

2.2 NVAC recommends consistent communications assessment and feedback pertaining to vaccine confidence. These include:

2.2.1 Creation of a Communication Assessment Infrastructure to assess vaccine sentiment and provide timely, accurate and actionable information related to vaccination confidence and acceptance to relevant stakeholders. This system should have the capability to regularly assess vaccine-related messaging environment (*e.g.,* to identify new or emerging concerns and questions) to assess understanding and effectiveness of population education and information materials and resources.

2.2.2 Identification, evaluation and validation of communication resources and approaches in terms of their effects on enhancing vaccine and vaccination confidence so that effective (''evidence-based/evidence-informed'') interventions and best practices can be shared and more widely used.

2.2.3 Creation of a repository of evidenced-based best practices for informing, educating, and communicating with parents and others in ways that foster or increase vaccine or vaccination confidence. This repository would be maintained and expanded as future evidence is compiled regarding messages, materials, and interventions that positively affect vaccine or vaccination confidence.

2.3 NVAC recommends the development of systems to support parent and community efforts that seek to promote vaccine confidence and vaccination.

2.4 NVAC recommends support for a community of practice or network of stakeholders who are actively taking steps to foster or grow vaccine confidence and vaccination; such a network can foster partnerships and encourage sharing of resources and best practices.

Focus Area 3: Healthcare Provider Strategies

3.1 NVAC recommends the development and deployment of evidence-based materials and toolkits for providers to address parent questions and concerns. These materials and toolkits should continue to be revised to incorporate the latest science and research.

3.1.1 A repository of evidence-based effective practices for providers should be an output of this effort.

3.2 NVAC recommends curriculum and communication training that focuses on vaccine confidence (*e.g.,* strategies and approaches for establishing or building confidence) be developed and made available for healthcare providers, including doctors, nurses, alternative providers, and ancillary care providers.

3.2.1 This training should encompass ''providers-in-training,'' such as students, residents, and interns as well as currently practicing physicians, nurses, and other healthcare providers through Continuing Medical Education (CMEs).

3.2.2 Clear and accessible information on vaccinations, the schedule and any changes to the immunization schedule should be developed specifically for providers and made available to them through resources they utilize most.

3.3 NVAC recommends the development of: (i) Provisional billing codes for vaccine counseling when vaccination is ultimately not given; and (ii) Pay for performance initiatives and incentives as measured by: (a) Establishment of an immunizing standard within a practice; and (b) Continued improvement in immunization coverage rates within a provider's practice.

Focus Area 4: Policy Strategies

4.1 NVAC recommends states and territories with existing personal belief exemption policies should assess their policies to assure that exemptions are only available after appropriate parent education and acknowledgement of the associated risks of not vaccinating, to

their child and community. Policies that do not do this should be strengthened.

4.1.1 Increased efforts should be made to educate the public and state legislatures on the safety and value of vaccines, the importance of recommended vaccinations and the ACIP schedule, and the risks posed by low or under-vaccination in communities and schools.

4.2 NVAC recommends information on vaccination rates, vaccination exemptions, and other preventative health measures (*e.g.,* whether a school has a school nurse, etc.) for an educational institution be made available to parents.

4.2.1 Encourage educational institutions and childcare facilities to report vaccination rates publicly (*e.g.,* via a school health grade or report).

4.3 NVAC recommends ''on-time vaccination'' should be included as a Quality Measure for all health plans, public and private, as a first line indicator of vaccine confidence. NVAC acknowledges that other issues, such as access, can also effect on time vaccination.

Final Recommendation

5.1 The NVAC recommends that the National Vaccine Program Office (NVPO) should work with federal and non-federal partners to develop an implementation plan to address vaccine confidence, including metrics, and report back to NVAC on progress, annually.

II. Request for Comment

NVPO, on behalf of the NVAC Vaccine Confidence Working Group, requests input on the draft report and draft recommendations. Please limit your comments to three (3) pages.

III. Potential Responders

HHS invites input from a broad range of stakeholders including individuals and organizations that have interests in immunization efforts and the role of HHS in advancing those efforts.

Examples of potential responders include, but are not limited to, the following:

—General public;
—advocacy groups, non-profit organizations, and public interest organizations;
—academics, professional societies, and healthcare organizations;
—public health officials and immunization program managers;
—pediatric provider groups including all physician and non-physician providers that administer healthcare services to children, including pharmacists; and
—representatives from the private sector, including those from health insurance organizations.

When responding, please self-identify with any of the above or other categories (include all that apply) and your name. Anonymous submissions will not be considered. Written submissions should not exceed three to five (3–5) pages. Please do not send proprietary, commercial, financial, business, confidential, trade secret, or personal information.

Dated: March 31, 2015.

Bruce Gellin,

Deputy Assistant Secretary for Health, Director, National Vaccine Program Office, Executive Secretary, National Vaccine Advisory Committee.

[FR Doc. 2015–07778 Filed 4–3–15; 8:45 am]

BILLING CODE 4150–44–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: Notification of Intent To Use Schedule III, IV, or V Opioid Drugs for the Maintenance and Detoxification Treatment of Opiate Addiction Under 21 U.S.C. 823(g)(2) (OMB No. 0930–0234)—Extension

The Drug Addiction Treatment Act of 2000 (''DATA,'' Pub. L. 106–310) amended the Controlled Substances Act (21 U.S.C. 823(g)(2)) to permit practitioners (physicians) to seek and obtain waivers to prescribe certain approved narcotic treatment drugs for the treatment of opiate addiction. The legislation sets eligibility requirements and certification requirements as well as an interagency notification review process for physicians who seek waivers. The legislation was amended in 2005 to eliminate the patient limit for physicians in group practices, and in 2006, to permit certain physicians to treat up to 100 patients.

To implement these provisions, SAMHSA developed a notification form (SMA–167) that facilitates the submission and review of notifications. The form provides the information necessary to determine whether practitioners (*i.e.*, independent physicians) meet the qualifications for waivers set forth under the new law. Use of this form will enable physicians to know they have provided all information needed to determine whether practitioners are eligible for a waiver.

However, there is no prohibition on use of other means to provide requisite information. The Secretary will convey notification information and determinations to the Drug Enforcement Administration (DEA), which will assign an identification number to qualifying practitioners; this number will be included in the practitioner's registration under 21 U.S.C. 823(f).

Practitioners may use the form for three types of notification: (a) New, (b) immediate, and (c) to notify of their intent to treat up to 100 patients. Under ''new'' notifications, practitioners may make their initial waiver requests to SAMHSA. ''Immediate'' notifications inform SAMHSA and the Attorney General of a practitioner's intent to prescribe immediately to facilitate the treatment of an individual (one) patient under 21 U.S.C. 823(g)(2)(E)(ii). Finally, the form may be used by physicians with waivers to certify their need and intent to treat up to 100 patients.

The form collects data on the following items: Practitioner name; state medical license number and DEA registration number; address of primary location, telephone and fax numbers; email address; name and address of