information to identify areas to strengthen the services provided to the participants. The Healthy Start Stakeholder Interview Guide is designed to collect more in-depth information about the Healthy Start services, the new maternal health and fatherhood initiatives, CAN activities, and activities developed to improve the Healthy Start benchmarks and achieve health equity.

Need and Proposed Use of the Information: The purpose of the data collection instruments is to obtain consistent information across all grantees about Healthy Start, its operations and outcomes. The data will be used to (1) conduct ongoing performance monitoring of the program; (2) provide credible and rigorous evidence of program effect on outcomes; (3) meet program needs for accountability, programmatic decision-making, and ongoing quality assurance; and (4) strengthen the evidence base and identify best and promising practices for the program to support sustainability, replication, and dissemination of the program.

Likely Respondents: Respondents will include project directors and staff for the Healthy Start Program Survey, members of the CANs for the Healthy Start Network Survey, program participants for the Healthy Start Participant Survey, and program and administrative staff for the Healthy Start Stakeholder Interview Guide.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information.

The total annual burden hours estimated for this ICR are summarized in the table below. The total number of responses was multiplied by the average burden per response and summed to produce the total annualized burden hours, which is estimated to be 600 hours. A break-down of these hours is detailed 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
Healthy Start Program Survey	101	1	101	1.00	101
Healthy Start Network Survey	[2] 600	1	600	0.33	198
Healthy Start Participant Survey.	[3] 750	1	750	0.25	188
Healthy Start Stakeholder Interview Guide	[4] 150	1	150	0.75	113
Total	1,601	....	1,601	....	600

HRSA specifically requests comments on (1) the necessity and utility 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, Executive Secretariat.

[FR Doc. 2022–15570 Filed 7–20–22; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Charter Renewal for the Advisory Commission on Childhood Vaccines

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

ACTION: Notice.

SUMMARY: In accordance with the Federal Advisory Committee Act (FACA), HHS is hereby giving notice that the charter for the Advisory Commission on Childhood Vaccines (ACCV) has been renewed. The effective date of the renewed charter is July 21, 2022.

FOR FURTHER INFORMATION CONTACT: CDR George Reed Grimes, M.D., MPH, Designated Federal Officer, Health Systems Bureau, HRSA, 5600 Fishers Lane, 08N186A, Rockville, Maryland 20857; (301)443–6634; or *ACCV@hrsa.gov.*

SUPPLEMENTARY INFORMATION: The ACCV provides advice and recommendations to the Secretary of HHS (Secretary) on policy, program development, and other matters of significance concerning the activities under 2119 of the Public Health Service Act (the Act) (42 U.S.C. 300aa-19), as enacted by Public Law 99–660, and as subsequently amended. The ACCV advises the Secretary on issues related to implementation of the National Vaccine Injury Compensation Program. Other activities of the ACCV include: recommending changes in the Vaccine Injury Table at its own initiative or as the result of the filing of a petition; advising the Secretary in implementing section 2127 of the Act regarding the need for childhood vaccination products that result in fewer or no significant adverse reactions; surveying federal, state, and local programs and activities related to gathering information on injuries associated with the administration of childhood vaccines, including the adverse reaction reporting requirements of section 2125(b) of the Act; advising the Secretary on the methods of obtaining, compiling, publishing, and using credible data related to the frequency and severity of adverse reactions associated with childhood vaccines; consulting on the development or revision of Vaccine Information Statements; and recommending to the Director of the National Vaccine Program research related to vaccine injuries which should be conducted to carry out the National Vaccine Injury Compensation Program.

The renewed charter for the ACCV was approved on July 1, 2022. The filing

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[2] This is the maximum number of responses for this data collection instrument.

[3] Ibid.

[4] Ibid.

date is July 21, 2022. Renewal of the ACCV charter gives authorization for the Commission to operate until July 21, 2024.

A copy of the ACCV charter is available on the ACCV's website at *https://www.hrsa.gov/advisory-committees/vaccines/index.html.* A copy of the charter also can be obtained by accessing the FACA database that is maintained by the Committee Management Secretariat under the General Services Administration. The website address for the FACA database is *https://www.facadatabase.gov/.*

Maria G. Button,

Director, Executive Secretariat.

[FR Doc. 2022–15573 Filed 7–20–22; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Youth Regional Treatment Center Aftercare Program

Announcement Type: New.

Funding Announcement Number: HHS–2023–IHS–YRTC–0001.

Assistance Listing (Catalog of Federal Domestic Assistance or CFDA) Number: 93.654.

Key Dates

Application Deadline Date: September 19, 2022.

Earliest Anticipated Start Date: October 4, 2022.

I. Funding Opportunity Description

Statutory Authority

The Indian Health Service (IHS) is accepting applications for a cooperative agreement for Youth Regional Treatment Center Aftercare Programs (Short Title: Youth Aftercare). This program is authorized under the Snyder Act, 25 U.S.C. 13; the Transfer Act, 42 U.S.C. 2001(a); and the Indian Health Care Improvement Act, 25 U.S.C. 1665a and 1665g. This program is described in the Assistance Listings located at *https://sam.gov/content/home* (formerly known as the CFDA) under 93.654.

Background

As a whole, the American Indian and Alaska Native (AI/AN) population is notably young, as 20.3 percent are youth, compared to the 16.6 percent of the non-AI/AN population. Among the total 2.3 million AI/AN youth, 46.7 percent are adolescents, 12 to 17 years of age, and 53.3 percent are young adults, 18 to 24 years of age. For purposes of examining youth outcomes, DBH applies the total youth age range, 12 to 24 years, for consistency with Tribal, Federal, and United Nations standards. For purposes of this effort, Youth Regional Treatment Centers (YRTCs) serve youth according to ages that their facilities are allowed to admit. There are multiple indicators that the behavioral health treatment requirements for AI/AN youth are unaddressed at this time. As one example, according to the CDC, as of 2020, AI/AN adolescent and young adult suicide rates have reached all-time highs. The suicide rate for youth, 15 to 24 year olds, is now 24.6 per 100,000; 1.9 times higher than the average of their non-AI/AN peers.

Meanwhile, AI/AN youth continue to experience an unprecedented crisis of unaddressed behavioral health treatment needs and requirements. The persistent risk is due to many personal and community factors, as well as notable structural factors, which undermine the development of an appropriately-fitted continuum of care (CoC) for AI/AN youth. As of 2021, the Division of Behavioral Health (DBH) completed an evaluation of a pilot Youth Aftercare project with one Tribal and one Federal YRTC. The pilot evaluation, Evaluation of the Youth Regional Treatment Center Aftercare Pilot Project, revealed an urgent need for examining the CoC and its effects on long-term outcomes among youth. The pilot evaluation was provided to all twelve YRTCs for their review before publication, as it provides a framework for planning the future AI/AN youth CoC, and the objectives of this effort. The goal in reframing the CoC is to address treatment efficacy, operational efficiency, and organizational suitability to optimally affect the physical, psychological, spiritual, cultural, familial, and social factors that sustain safety, sobriety, and employability outcome goals.

This program will support DBH and the YRTCs efforts to develop and sustain a CoC that fully supports explicit, measurable outcomes of safety, sobriety, and employability among AI/AN youth after discharge from a YRTC. The benefit of focusing on employability includes the array of factors that affirm whole-person wellness, community engagement, long-term contributions of the individual back to the community, and the therapeutic experience of developing, testing, and generalizing personal capabilities.

Purpose

The goal of the Youth Aftercare cooperative agreement is to help AI/AN youth pursue and sustain safety, sobriety, and employability after release from a YRTC. While aftercare support services may not exist in a youth's home community, the YRTC can lead the development of effective aftercare methods. The YRTC Aftercare cooperative agreement awardee (''awardee'') will pursue the above stated goal in each AI/AN client who separates from their respective YRTCs. In addition to the stated goal, a focus of this funding opportunity is to understand and overcome aftercare management and performance barriers that affect the capacity of YRTCs and the IHS to develop effective and responsive solutions within the scope of the AI/AN Youth CoC, given AI/AN youth's behavioral health treatment requirements.

In alignment with the IHS 2019–2023 Strategic Plan Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people, the awardees will work closely with community-based services/programs to strengthen partnerships that affect youths' ability to use coordinated services within their CoC. The awardee will examine and monitor its operational requirements, such as staffing, data collection, case coordination tools, and communication tools to readily inform the IHS of changing requirements and challenges. Such examinations may require engagements with the IHS, technical advisors, or others who can provide suitable analyses and planning with the YRTCs.

The IHS will award funding for the provision of aftercare services for two YRTCs, which are operated by either a Tribe or a Tribal Organization.

Required Activities

The awardee is required to (1) design inpatient case management plans that focus on achieving the whole scope of treatment objectives and outcomes that will be addressed within the inpatient and Aftercare Domain (*i.e.,* Outpatient Therapy, Independent Aftercare, and Personal Efficacy Programs) described in the pilot evaluation report; (2) establish and sustain a full-time aftercare coordinator; (3) coordinate and communicate with aftercare clients their specific post-inpatient therapeutic service plans, and their appropriate use of such services within the scope of whole-person wellness goals; (4) arrange or provide counseling and coaching (in-person and/or remote) to the client to help develop measurable improvements in clients' personal efficacy in achieving goals; (5) reinforce the appropriate treatment engagement and services