comments can be mailed to: GSA San Luis EIS, c/o LMI, 7940 Jones Branch Drive, Tysons, VA 22102. All comments must be received by July 21, 2020, in order to be considered for the Final EIS.

**SUPPLEMENTARY INFORMATION:** During the DEIS review period in April 2019, multiple comments were received, including one comment which identified a new alternative to be included in the analysis. Therefore, GSA determined that the Draft EIS would be re-released for public review that includes the new alternative. The revised DEIS describes the project purpose and need, the alternatives being considered, and the potential impacts of each alternative on the existing environment. As the lead agency for this undertaking, GSA is acting on behalf of its major tenant at the facility, the Department of Homeland Security's U.S. Customs and Border Protection (CBP).

The availability of the revised DEIS was announced in a separate **Federal Register** notice on March 31, 2020 (85 FR 17890, pp. 17890–17891).

**Virtual Public Meeting**

The virtual public meeting will be held via a Zoom Webinar. Preregistration is strongly encouraged. The meeting will include a presentation by GSA and an opportunity for interested parties to provide comments. Comments can also be provided prior to the meeting via email to *osmahn.kadri@gsa.gov.*

**Jared Bradley,**

*Director, Portfolio Management Division, Pacific Rim Region, Public Buildings Service.*

[FR Doc. 2020–14103 Filed 6–30–20; 8:45 am]

**BILLING CODE 6820–YF–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Agency for Healthcare Research and Quality

### Agency Information Collection Activities: Proposed Collection; Request

**AGENCY:** Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services (HHS).

**ACTION:** Request for Information; notice of extension of comment period.

**SUMMARY:** For the ''*Opioid Management in Older Adults*'' project, AHRQ is seeking to identify innovative approaches to managing opioid medications for chronic pain that are particularly relevant for *older adults.* Use of long-term opioid therapy in older adults can be especially problematic because of increased risks such as delirium, falls, and dementia. Through this notice, the comment period has been extended to August 30, 2020. The subject matter content remains unchanged from the original notice which was previously published on March 18, 2020.

**DATES:** Information must be received by August 30, 2020.

**ADDRESSES:** Written comments should be submitted by email to: *Opioids_OlderAdults@abtassoc.com.*

**FOR FURTHER INFORMATION CONTACT:** Parivash Nourjah, *Parivash.nourjah@ahrq.gov,* or 301–427–1106.

**SUPPLEMENTARY INFORMATION:** The United States is in the midst of an unprecedented opioid epidemic that is affecting people from all walks of life. Regulators and policy makers have initiated many activities to curb the epidemic, but relatively little attention has been paid to the growing toll of opioid use, opioid misuse, and opioid use disorder (OUD) among older adults.

The opioid crisis in older adults is strongly related to challenges in prescription opioid management in this population. Older adults have a high prevalence of chronic pain and are especially vulnerable to suffering adverse events from opioid use, making safe prescribing more challenging even when opioids are an appropriate therapeutic choice. Identifying adverse effects due to opioid use, misuse or abuse is complicated further by factors such as co-occurring medical disorders that can mimic the effects of opioid use. There is also a risk of attributing clinical findings in older adults (*e.g.,* personality changes, falls/balance problems, difficulty sleeping, and heart problems) to other conditions that are also common with age. If adverse events due to opioid prescriptions are identified, finding appropriate alternatives for pain management can be challenging if other pharmacologic options (such as NSAIDS) are contraindicated or mobility issues limit access to other therapeutic options.

Diagnosis of substance use disorders is also more complicated in this population. Clinicians may not associate drug misuse or addiction with older adults or they may be inadequately trained in identification and treatment of opioid misuse and OUD among older adults, and hence may not monitor for the signs of opioid use disorder in this population.

Successfully optimizing the prescribing and use of opioids in older adults will require addressing the issue at many points along the care continuum where older adults may need additional attention or a different approach. AHRQ wants to identify specific tools, strategies and approaches to opioid management in older adults throughout the breadth of the care delivery continuum, from avoiding opioid initiation to screening for opioid misuse and opioid use disorder, as well as approaches to opioid tapering in older adults.

AHRQ is interested in all innovative approaches that address the opioid management concerns in older adults listed above, but respondents are welcome to address as many or as few as they choose and to address additional areas of interest not listed.

Strategies and approaches could come from a variety of health care settings including, but not limited to, primary care and other ambulatory care clinics, emergency departments, home health care organizations, skilled nursing care settings, and inpatient care. Other sources of these strategies might include health care payers, accountable care organizations, and organizations that provide external quality improvement support. Some of the examples of the types of innovations we are looking for might be specific tools or workflows that support providers to assess the risk/benefit balance of opioids within a multidisciplinary approach in pain management; to optimize and monitor the opioid prescribing when appropriate, including tapering strategies; to screen and treat for opioid misuse or opioid use disorder; or to involve family or other caregivers of an older adult in conversations about opioid safety. Descriptions of strategies or approaches should include the setting where it is deployed and the type of patient population served.

This RFI is for planning purposes only and should not be construed as a policy, solicitation for applications, or as an obligation on the part of the Government to provide support for any ideas in response to it. AHRQ will use the information submitted in response to this RFI at its discretion, and will not provide comments to any respondent's submission. However, responses to the RFI may be reflected in future solicitation(s) or policies. Respondents are advised that the Government is under no obligation to acknowledge receipt of the information received or provide feedback to respondents with respect to any information submitted. No proprietary, classified, confidential or sensitive information should be included in your response. The Government reserves the right to use any non-proprietary technical information in any resultant solicitation(s). The contents of all

submissions will be made available to the public upon request. Submitted materials must be publicly available or able to be made public.

Dated: June 25, 2020.

**Virginia Mackay-Smith,**

*Associate Director.*

[FR Doc. 2020–14156 Filed 6–30–20; 8:45 am]

**BILLING CODE 4160–90–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

**[Docket No. CDC–2018–0094; NIOSH–321]**

### Infectious Diseases and Circumstances Relevant to Notification Requirements: Definition of Emergency Response Employee

**AGENCY:** Centers for Disease Control and Prevention, Health and Human Services (HHS).

**ACTION:** Notice of availability and response to comments.

**SUMMARY:** The Centers for Disease Control and Prevention (CDC), within the Department of Health and Human Services (HHS), has added a definition of the term ''emergency response employees'' to the definitions section of the document entitled ''Implementation of Section 2695 (42 U.S.C. 300ff-131) Public Law 111–87: Infectious Diseases and Circumstances Relevant to Notification Requirements.'' This list of potentially life-threatening infectious diseases to which emergency response employees may be exposed and companion guidelines has been re-published by the National Institute for Occupational Safety and Health (NIOSH) and is available on the NIOSH website.

**FOR FURTHER INFORMATION CONTACT:** Rachel Weiss, Office of the Director, NIOSH; 1090 Tusculum Avenue, MS:C–48, Cincinnati, OH 45226; telephone (855) 818–1629 (this is a toll-free number); email *NIOSHregs@cdc.gov.*

**SUPPLEMENTARY INFORMATION:**

#### I. Statutory Authority

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (Pub. L. 101–381) was reauthorized in 1996, 2000, 2006, and 2009. The most recent reauthorization, the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Pub. L. 111–87), amended the Public Health Service Act (PHS Act, 42 U.S.C. 201–300ii) and requires the HHS Secretary to establish the following: a list of potentially life-threatening infectious diseases, including emerging infectious diseases, to which emergency response employees (ERE) may be exposed in responding to emergencies; guidelines describing circumstances in which EREs may be exposed to these diseases, taking into account the conditions under which emergency response is provided; and guidelines describing the manner in which medical facilities should make determinations about exposures.

In a **Federal Register** notice published on July 14, 2010, the HHS Secretary delegated this responsibility to the CDC Director.[1] The CDC Director further assigned the responsibility to the NIOSH Director and formally re-delegated the authority to develop the list and guidelines to NIOSH on August 27, 2018.[2]

#### II. Background

On November 2, 2011, CDC published a notice in the **Federal Register** entitled *Implementation of Section 2695 (42 U.S.C. 300ff-131) Public Law 111–87: Infectious Diseases and Circumstances Relevant to Notification Requirements.*[3] The notice included ''a list of potentially life-threatening infectious diseases, including emerging infectious diseases, to which EREs may be exposed in responding to emergencies . . .; guidelines describing circumstances in which employees may be exposed to these diseases; and guidelines describing the manner in which medical facilities should make determinations about exposures.'' The list and guidelines published in that notice did not include a definition for ''emergency response employee.''

In a request for information (RFI) published in the **Federal Register** on October 17, 2018,[4] CDC solicited input on a definition of ''emergency response employee.'' In the RFI, CDC explained that Congress included such a definition in earlier iterations of the Ryan White Act but inadvertently omitted it from the current version of the Act. Therefore, interested parties were invited to participate in the RFI by submitting written views, opinions, recommendations, and data regarding the definition of the term ''emergency response employee.''

Five submissions were received from the following commenters: Two private individuals, a professional organization representing fire chiefs, a union representing emergency response employees, and one city emergency management agency; all commenters were supportive of restoring the definition of ''emergency response employee'' to the publication. Two commenters asked that the definition offered in the RFI be revised to remove the word ''employee;'' change ''funeral service practitioners'' to ''coroner'' or ''medical examiner;'' and add the terms ''rescuers'' and ''emergency management personnel.''

After careful consideration of the requested revisions, CDC has determined that adopting the original statutory definition, without change, in the definitions section accompanying the NIOSH list and guidelines allows the notification provisions to be implemented as Congress originally intended. Further, the definition references ''other individuals,'' which allows discretion in determining whether individuals who are employed in job categories other than those enumerated can be considered EREs, including the specific groups recommended by the commenters. Therefore, CDC is retaining the definition of ''emergency response employee'' provided in the RFI:

> firefighters, law enforcement officers, paramedics, emergency medical technicians, funeral service practitioners, and other individuals (including employees of legally organized and recognized volunteer organizations, without regard to whether such employees receive nominal compensation) who, in the course of professional duties, respond to emergencies in the geographic area involved.

NIOSH has updated the guidelines and list with the ERE definition and has re-published them on the NIOSH Ryan White HIV/AIDS Treatment Extension Act of 2009 topic page, at *https://www.cdc.gov/niosh/topics/ryanwhite/.*

**John J. Howard,**

*Director, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention.*

[FR Doc. 2020–14201 Filed 6–30–20; 8:45 am]

**BILLING CODE 4163–18–P**

[1] 75 FR 40842.

[2] 83 FR 50379 (October 4, 2018).

[3] 76 FR 67736.

[4] 83 FR 52454.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[Document Identifier: CMS–10633 and CMS–10744]**

### Agency Information Collection Activities: Proposed Collection; Comment Request

**AGENCY:** Centers for Medicare & Medicaid Services, Health and Human Services (HHS).