risk due to recent changes in health care delivery and financing? If so, how are academic health centers addressing these?

What Federal policy changes, if any, are needed to assist academic health centers in providing quality health services to vulnerable and under served populations?

How are the special services (e.g., burn units, trauma Centers, organ transplantation programs, etc.) that are frequently, if not primarily, performed at academic health centers being affected by the changing health care environment? If these special services are being adversely affected, how are academic health centers addressing this? Can/should Federal policy assist these institutions?

Access to Capital

What are the capital needs of academic health centers? Do academic health centers have access to adequate capital resources to support the education, research and service mission of academic health centers?

Are the Federal policies that influence access to capital resources appropriate? If not, what Federal policy changes are needed to facilitate academic health centers' access to capital?

DHHS Initiative on Academic Health Centers

Description of Academic Health Centers

Academic health centers are major complexes comprised of a school of medicine, at least one other health professions school (nursing, dentistry, allied health, public health, pharmacy, etc.) and one or more teaching hospitals. There are over 100 academic health centers in the United States, more than 75 percent having three or more health professions schools. These centers may be components of private or public universities or State university systems, or they can be freestanding institutions.

Mission of Academic Health Centers

Academic health centers are an integral part of the American health care system. These centers produce valuable public goods for the country, including 40 percent of the health research and development and thirty three percent of the highly specialized, complex care for patients with major trauma as injuries or burns, AIDS, and other intensive care. They are a principal resource for the training and education of the future health care professional workforce. Academic health centers—especially publicly owned ones—provide over one third of the nation's uncompensated (charity and bad debt) health care.

Challenges Facing Academic Health Centers

Many changes in the evolving health care environment, including the rapid expansion of managed care, are posing a number of serious challenges for these centers and the health professions workforce. These challenges include fiscal survival and stability in a competitive health care marketplace, diminished subsides for the academic mission in research and education, urgent demand to develop a strong capacity in primary (general) care and training of future health professionals in ambulatory (non-hospital) settings, information technology needs that are quite expensive, and external pressures for increased accountability as a public goods resource.

Stakeholder of Academic Health Centers

Academic health centers are linked to a variety of entities such as universities, local-State-Federal government agencies, managed care organizations, health insurance industry, pharmaceutical companies, telecommunications companies and the general business community, among many others. Moreover, these centers are closely tied to the health and economy of the communities they serve.

Federal Government Partnership

DHHS oversees numerous programs that directly or indirectly provide financial, physical, human, and technical resources to the academic health center enterprise. These resources support graduate medical education and other health professions training and education, biomedical and other health research, institutional and student loan programs, and services to Medicare and Medicaid participants. The Veteran's Administration and the Department of Defense are additional components of the Federal government than help support academic health centers.

DHHS Initiative

This initiative was established to update and develop relevant policy at the Federal level that can ensure the academic health centers' capacity to achieve their public good mission in a new, evolving health care system. DHHS Secretary Shalala has appointed Dr. Ciro Sumaya, Deputy Assistant Secretary for Health, to lead an interagency policy development task force focusing on the future of the centers. The task force will also work with the Departments of Veterans Affairs and Defense, State governments, the academic community, and other public and private sectors partners in this process. Recommendations on policy options and actions are to be submitted to the Secretary by the end of September 1997. The recommendations will address the current development of the health professions work force as well as financial, research, and service infrastructure issues facing academic health centers.

Dated: July 23, 1997.

John M. Eisenberg,

Acting Assistant Secretary for Health.

[FR Doc. 97–19982 Filed 7–25–97; 12:24 am]

BILLING CODE 4160–17–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Notice of Meeting

AGENCY: Office of Disease Prevention and Health Promotion, HHS.

ACTION: Commission of dietary supplement labels: notice of meeting #9.

SUMMARY: The Department of Health and Human Services (HHS) is providing notice of the ninth meeting of the Commission on dietary supplement labels.

DATES: The Commission intends to hold its meeting on August 14, 1997, from 8:30 a.m. to 4:30 p.m. and on August 15, 1997, from 8:30 a.m. to approximately 3:00 p.m., E.S.T., at the Hyatt Regency Reston, Reston Town Center, 1800 Presidents Street, Reston, Virginia 20190. The meeting is open to the public; seating is limited.

FOR FURTHER INFORMATION CONTACT: Kenneth D. Fisher, Ph. D., Executive Director, Commission on Dietary Supplement Labels, Office of Disease Prevention and Health Promotion, Room 738G, Hubert H. Humphrey Building, 200 Independence Ave. S.W., Washington, D.C. 20201, (202) 690–7102.

SUPPLEMENTARY INFORMATION: Pub. L. 103–417, Section 12, authorized the establishment of a Commission on Dietary Supplement Labels whose seven members have been appointed by the President. The appointments to the Commission by the President and the establishment of the Commission by the Secretary of Health and Human Services reflect the commitment of the President and the Secretary to the development of a sound and consistent regulatory policy on labeling of dietary supplements.

The Commission is charged with conducting a study and providing recommendations for regulation of label claims and statements for dietary supplements, including the use of

supplemental literature in connection with their sale and, in addition, procedures for evaluation of label claims. The Commission is evaluating how best to provide truthful, scientifically valid, and non-misleading information to consumers in order that they may make informed health care choices for themselves and their families. The Commission's study report may include recommendations on legislation, if appropriate and necessary.

The Commission made a draft of its report available for public comment on June 24, 1997. The purpose of meeting #9 is to review comments and information received from the public and to discuss preparation of the Commission's final report.

The Commission meeting agenda will include approval of minutes of the previous meeting, review of comments and information submitted by the public, and discussion of possible revisions of the draft report and procedures for final report completion. The open meeting may be recessed for short time periods on Thursday afternoon, August 14, 1997, and on Friday morning, August 15, 1997, at the call of the Chair, to allow members of the Commission to redraft portions of the report. Following such recesses, if any, the revisions will be presented to the full Commission in its open meeting.

The meeting is open to the public, however seating is limited. If you will require a sign language interpreter, please call Sandra Saunders (202) 690–7102 by 4:30 p.m. E.S.T. on August 4, 1997.

Dated: July 17, 1997.

Susanne A. Stoiber,

Acting Deputy Assistant Secretary for Health, (Disease Prevention and Health Promotion), U.S. Department of Health and Human Services.

[FR Doc. 97–19909 Filed 7–28–97; 8:45 am]

BILLING CODE 4160–17–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30DAY–16–97]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Office on (404) 639–7090. Send written comments to CDC, Desk Officer; Human Resources and Housing Branch, New Executive Office Building, Room 10235; Washington, DC 20503. Written comments should be received within 7 days of this notice.

Proposed Project

1. The National Home and Hospice Care Mail Survey (NHHCMS)—(0920–0298)—Revision—The National Center for Health Statistics (NCHS) is requesting an emergency review and clearance of the above named data collection in 1997. The use of the regular clearance process for this survey would preclude collection of home health care data in 1997, thereby disrupting the provisions of annual trend data for this dynamic sector in the health care delivery system. A decision regarding this request is needed by August 8, 1997. The National Home and Hospice Care Survey was conducted in 1992, 1993, 1994 and 1996. It is part of the Long-Term Care component of the National Health Care Survey. Section 306 of the Public Health Service Act states that the National Center for Health Statistics ''shall collect statistics on health resources * * * (and) utilization of health care, including utilization of * * * services of hospitals, extended care facilities, home health agencies, and other institutions.'' NCHS data are used to examine this most rapidly expanding sector of the health care industry. Data from the NHHCS are widely used by the health care industry and policy makers for such diverse analyses as the need for various medical supplies; minority access to health care; and planning for the health care needs of the elderly. The NHHCS also reveals detailed information on utilization patterns, as needed to make accurate assessments of the need for and costs associated with such care. Data from earlier NHHCS collections have been used by the Congressional Budget Office, the Bureau of Health Professions, the Maryland Health Resources Planning Commission, the National Association for Home Care, and by several newspapers and journals.

Additional uses are expected to be similar to the uses of the National Nursing Home Survey. The mail survey version is an abbreviated form used to collect basic trend data in years in which the full NHHCS is not in the field. NHHCMS data cover: baseline data on the characteristics of home health agencies and hospices including number of patients served, ownership, Medicare and Medicaid certification, and services provided. Data collection is planned for the period October 1997–January 1998. Survey design is in process now. The total annual burden hours are 200.

Respondents	Number of respondents	Number of responses/ respondent	Average burden/response (in hours)
Hospices and Home Health Care Agencies	1,200	1	0.166