

Mouth, Throat, and Esophagus

Heartburn (*Reflux Esophagitis*) - Inflammation of the esophagus due to the backwash of stomach contents into the esophagus.... 8 11

Hiatus Hernia - A protrusion of part of the stomach through the diaphragm into the chest cavity... 11 12

Swallowing Disorders (*Dysphagia*) - Difficulty in swallowing or a sensation that food is getting stuck in the neck or in the chest.... 8 9 12

Esophageal Varices - Enlarged veins located in the lining of the esophagus... 2 9 11 12

Liver

Hepatitis - Inflammation of the liver.... 2 5 11

Cirrhosis - A chronic liver disease in which the liver cells are damaged and replaced by scar tissue.... 2 5 11

Hemochromatosis - Accumulation of iron in many tissues (liver, heart, pancreas, joints, etc.) causing scarring, damage and symptoms of arthritis, diabetes, heart disease and liver cirrhosis... 2 7

Gallbladder and Biliary Tree

Cholecystitis - Inflammation of the gallbladder... 2 11

Gallstones - Solid material that forms in the gall bladder of bile ducts... 2 11

Biliary Atresia - Congenital defect in bile ducts in children which causes jaundice and usually requires liver transplantation to preserve life.... 2

Abdominal Cavity

Peritonitis - Inflammation of the abdominal cavity.... 12

Hernia - An Abnormal bulging or protrusion of the intestine or other organs through an opening in the abdominal wall.... 11 12

Anus and Rectum

Fissures - Cracks in the lining of the anus.... 8 12

Hemorrhoids - Enlarged veins in the anal area... 11

Proctitis - Inflammation of the rectum and anus... 4 8 11 12

Fistula - An abnormal opening connecting the rectum and the outside of the body.... 4 8 9 11

Functional Disorders

Indigestion - Painful, difficult, or disturbed digestion causing some combination of nausea, regurgitation, vomiting, heartburn, bloating, and abdominal pain or fullness.... 1 8 11 12

Irritable Bowel Syndrome (*Spastic Colon*) - An intestinal disorder causing gas, abdominal pain, diarrhea and/or constipation... 8 9 11 12

Constipation - Infrequent, difficult, or inadequate bowel movements... 8 11 12

Colic - Abdominal cramps and often increased gas, usually in infants... 12

Incontinence - Unable to hold stool in colon and rectum... 8

Stomach and Duodenum

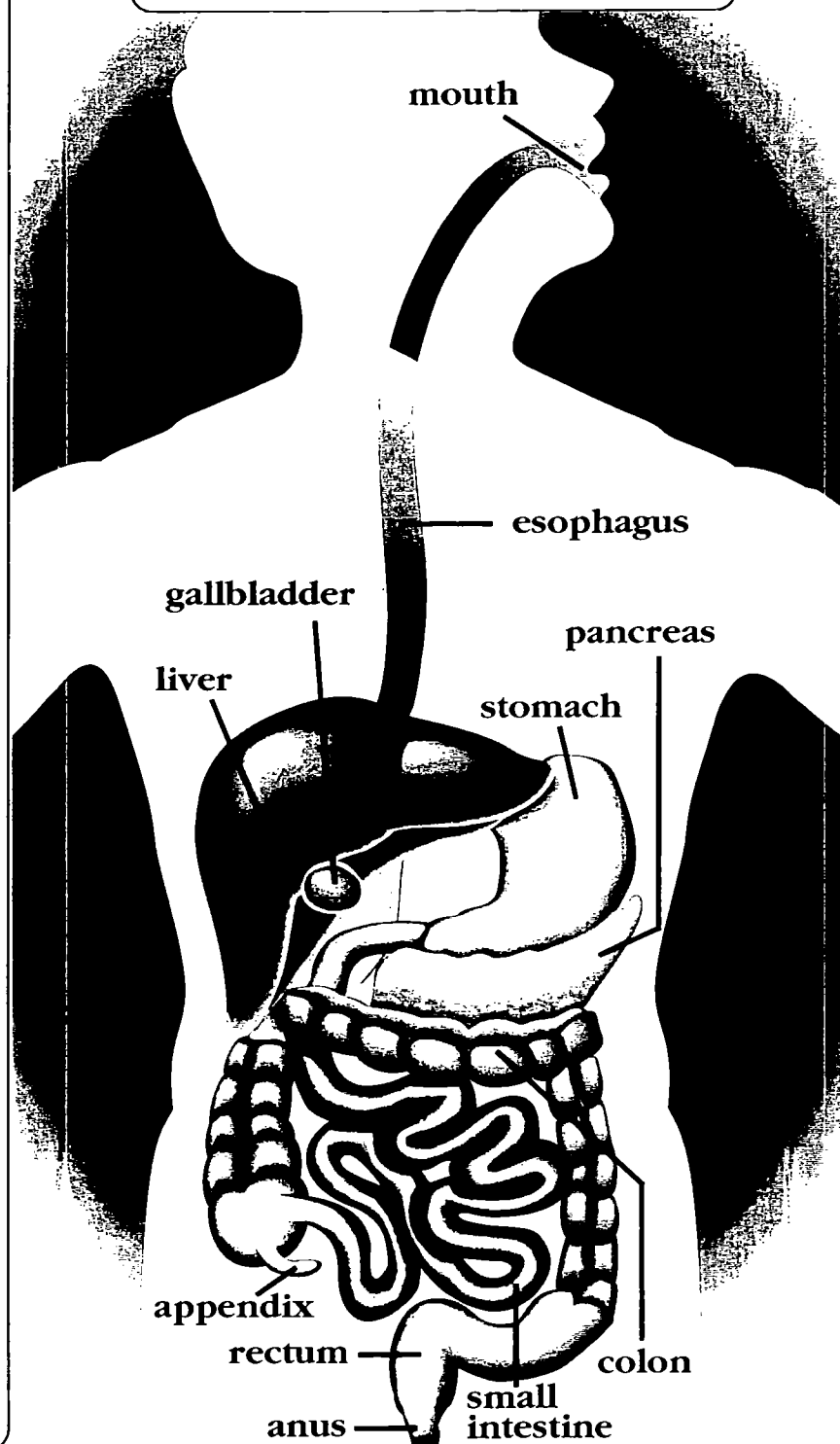
Duodenal Ulcer - An open sore on the lining of the duodenum.... 3 11

Gastric (Stomach) Ulcer - An open sore on the lining of the stomach... 3 11

Pyloric Stenosis - A stricture at the end of the stomach

Gastritis - Inflammation of the stomach lining... 3 12

The Gastrointestinal Tract and Digestive Diseases



Pancreas

Pancreatitis - Inflammation of the pancreas that may be acute (of short duration) or chronic.... 11

Cystic Fibrosis - An inherited disease that affects the pancreas and mucous and sweat glands, causing digestive problems, difficult breathing, and susceptibility to respiratory infections.... 9

Intestines

Diarrhea... 8 11 12

Infectious and Parasitic Diseases

Inflammatory Bowel Diseases... 4 9 11

Ulcerative Colitis - A chronic inflammatory disease of the lining of the large intestine (colon).... 4 9 11

Crohn's Disease - (*Regional Enteritis, Ileitis*) - a chronic, inflammatory disease that can affect any part of the GI tract, but most often the ileum or colon.... 4 9 11

Diverticular Diseases

Diverticulosis - A condition in which there are little sacs (diverticula) in the wall of the colon; common among older people.

Diverticulitis - Inflamed diverticula.

Appendicitis - Inflammation of the appendix.

Polyp - A benign (sometimes premalignant) tumor of the lining of the colon.

Ischemic Bowel Disease - Tissue damage due to inefficient blood supply to the intestine.... 9

Intestinal Obstruction - Mechanical or physical blockage.... 12

Malabsorption Syndromes - Any condition in which the intestine is unable to absorb food.... 8 9 12

Celiac Sprue - (*Celiac Disease, Gluten Intolerance, Nontropical Sprue, Gluten Sensitive Enteropathy*) A condition in which gluten (a protein found in wheat, rye, oats, and barley) causes abnormal immune response in the bowel lining, leading to tissue destruction and malabsorption.... 1 6

Lactose Intolerance - A deficiency of the enzyme lactase (produced in the intestine) needed to digest the lactose in dairy products.... 3 11

Ostomy - (*Colostomy, Ileostomy*) - A surgical diversion of the intestine to manage waste discharge after removal of some or all of the colon.... 10

"Cancer can affect any organ of the digestive system, most commonly the esophagus, stomach, gall bladder, pancreas, liver, colon and rectum. Colorectal cancer is the third leading cause of cancer death in both men and women."

In addition to the conditions listed, other tumors, metabolic disorders, and congenital disorders and diseases can affect any portion of the digestive system. The gastrointestinal tract can also be injured by various drugs, alcohol and toxins, as well as by physical trauma.

If you wish information on any of the above conditions, use the number next to the condition to identify the source. (see list of organizations).

Each of the diseases in this brochure is coded to direct you to a voluntary organization and/or the National Digestive Disease Information Clearinghouse for more information on that disease and other digestive diseases.

The voluntary organizations listed below are dedicated to helping patients by providing educational materials, identifying self-help groups for patients and families, and providing referrals to specialists and to private government agencies.

The National Digestive Disease Information Clearinghouse, (a branch of the National Institutes of Health) provides the public, patients, and their families with information on digestive diseases. The Clearinghouse has current fact sheets on specific diseases available to you upon request.

To obtain the information from one of our voluntary organizations, send a large, self addressed stamped envelope with your request. To obtain information from the Clearinghouse, simply write to the address indicated.

Voluntary Organizations

① American Celiac Society-Dietary Support Coalition

58 Musano Court
West Orange, NJ 07052
(201) 325-8837

② American Liver Foundation

1425 Pompton Avenue
Cedar Grove, NJ 07009-1000
(800) Go-Liver (465-4837)
(888) 4-Hep-ABC (443-7222)
www.liverfoundation.org

③ Center for Ulcer Research and Education Foundation

11301 Wilshire Boulevard
Building 115, Room 115
Los Angeles, CA 90073
(310) 312-0547

④ Crohns & Colitis Foundation of America

386 Park Avenue South
New York, NY 10016-8804
(212) 685-3440
(800) 932-2423
www.ccfaf.org

⑤ Hepatitis Foundation International

30 Sunrise Terrace
Cedar Grove, NJ 07009-1423
1-800-891-0707
www.hepfi.org

⑥ Gluten Intolerance Group of North America

P.O. Box 23053
Seattle, WA 98102-0353
(206) 325-6980
(206) 320-1172 (Fax)

⑦ Hemochromatosis Foundation

P.O. Box 8569
Albany, NY 12208
(518) 489-0972

⑧ International Foundation for Functional Gastrointestinal Disorders

P.O. Box 17864
Milwaukee, WI 53217
(888) 964-2001
www.execpc.com/iffgd

⑨ Oley Foundation for Home Parenteral and Enteral Nutrition

214 Hun Memorial
Albany Medical Center
Albany, NY 12208
(800) 776-OLEY

⑩ United Ostomy Association

19772 MacArthur Blvd.
Suite 200
Irvine, CA 92612
(714) 660-8624
(800) 826-0826
www.uoa.org

⑪ National Digestive Disease Information Clearinghouse

P.O. Box NDDIC
9000 Rockville Pike
Bethesda, MD 20892
1-800-891-5389

⑫ American Society of Adults with Pseudo-Obstruction, Inc.

19 Carroll Road
Woburn, MA 01801-6161
(781) 935-9776

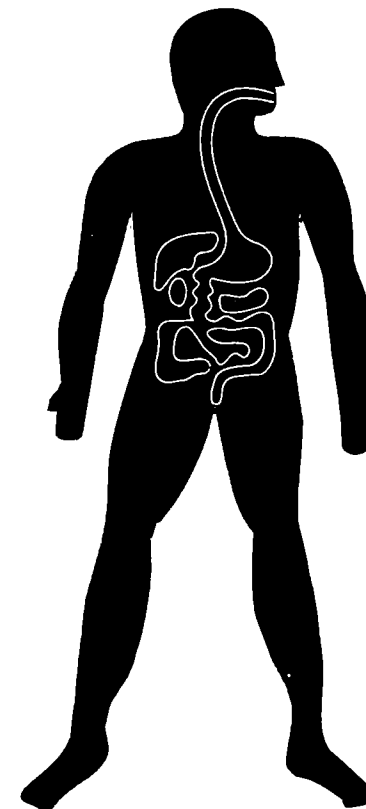
Professional Organizations

American Association for the Study of Liver Disease
American College of Gastroenterology
American Gastroenterological Association
American Society for Gastrointestinal Endoscopy
Federated Societies of Gastroenterology and Hepatology
New York Society of Gastrointestinal Endoscopy
North American Society for Pediatric Gastroenterology and Nutrition
Pennsylvania Society of Gastroenterology
Society for Surgery of the Alimentary Tract
Society of Gastroenterology Nurses and Associates, Inc.
Wound, Ostomy and Continence Nurses Society

Digestive Disease National Coalition
507 Capitol Court, Suite 200
Washington, D.C. 20002
(202) 544-7497
(202) 546-7105 Fax

When You Suffer The Pain and Discomfort of Digestive Disease

Here's How We Can Help



Digestive Disease National Coalition



F A C S I M I L E

DATE: 9/3/89

TO: Neera Tanden

FAX#: 456-2878

FROM: Elizabeth Summy
Deputy Chief of Staff

Phone: 202/690-7431 Fax: 202/401-5783

COMMENTS:

Background on grants & science article.
Please give me a call when you get the chance.

6 Pages [including this cover]



Fax Transmittal

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From Paul Van Nuyl
Cover Sheet plus 4 Pages Transmitted

Fax to:
Neeraj T.

Message

As requested

Note that the info
about the Science
article is embargoed
until 4 p.m. Sept 3.

SEATTLE GASTROINTESTINAL PROGRAM PROJECT

Researchers have learned that colorectal cancer, like all malignancies, is at its root a genetic disease. It arises when certain key genes in a cell become damaged and either stop working or function incorrectly. With these regulatory genes out of order, a cell gains the ability to act on its own, dividing on its own unregulated schedule and putting a person at risk for cancer.

Though scientists already have discovered a great deal about how some of these key genes work, they still know little about what it is that actually causes the damage, information that will be critical in designing effective strategies to prevent or delay the onset of colorectal cancer.

The Seattle Gastrointestinal Program Project, however, should help to change this. Led by the Fred Hutchinson Cancer Research Center, this \$8 million, four-year study will apply the insights of laboratory research to prevent, diagnose, and treat colorectal cancer in humans.

The key to this task will be to assess the link between three biological processes:

- Oxidative damage to DNA, which occurs when a highly reactive byproduct of the oxygen that we breathe gradually damages, or mutates, our DNA;
- The cell's subsequent inability to repair this damage;
- The cells failure to commit suicide, a process called apoptosis, that normally is the fate of damaged cells.

The first major project involves people with ulcerative colitis, a chronic inflammation of the colon that is a possible precursor to cancer. Researchers will study these people in hopes of

gaining a better understanding of the role of these three processes in causing cancer. The project also should help scientists identify new ways of monitoring people at risk for colorectal cancer and to test new strategies to reduce their cancer risk.

Another major project will measure some of the early pathologic changes in the lining of the colon and rectum, attempting to discriminate between those who are at high and low risk of developing colorectal cancer. The study aims to develop sensitive and more precise ways of screening for colorectal cancer than fecal-occult blood testing and that also are less invasive than sigmoidoscopy and colonoscopy.

The Seattle Gastrointestinal Program Project involves the following Seattle health care institutions: University of Washington Schools of Medicine and Dentistry, Group Health Cooperative, Veterans Administration, Puget Sound Health Care System, and Virginia Mason Medical Center.

For more information, contact:

Kristen Lidke Woodward
Media Relations Manager
Fred Hutchinson Cancer Research Center
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Seattle, WA 98109-1024
(206) 667-5095



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Web Site: www.med.jhu.edu/cancerctr/

Hopkins Researchers Discover Key Target in Molecular Pathway that Initiates Colon Cancer

In the latest of a series of discoveries about colon cancer genes, researchers at the Johns Hopkins Oncology Center and the Howard Hughes Medical Institute have discovered a connection between two of them, APC and c-MYC, that conspires to initiate almost all colon cancers. Their findings are reported in the September 4, 1998, issue of *SCIENCE*.

The APC tumor suppressor gene, which acts like a brake on cell growth, loses that ability when mutated. The c-MYC gene has long been known as an oncogene, a type of gene that promotes cancer cell growth. Now, Hopkins scientists Bert Vogelstein, M.D., and Kenneth W. Kinzler, Ph.D., have found that the mutated APC gene controls the expression of c-MYC activation. APC was first identified and linked to colon cancer in 1991 by research teams including those led by Vogelstein and Kinzler.

Every person carries the c-MYC oncogene, but it remains under control in the colon until APC inactivation awakens it, generating the distinctive uncontrolled cell growth that mark cancers.

"Cancer is like a car with the accelerator pushed to the floor and failing brakes," says Vogelstein, professor of oncology at Hopkins and a Hughes scholar.

"In this case, c-MYC is the accelerator and APC is the failed brakes," he explains. When suppressor genes, like APC, malfunction either through heredity or as a result of exposure to carcinogens, cells get signals to continue multiplying until they are out of control. "Now we know that in colon cancer a mutated APC gene signals to c-MYC," Vogelstein says.

(More)

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CHIEF OF STAFF

THU 16:04 FAX 202 4015783 98/09/09

-page 2-

The new findings about the APC pathway and how it functions may suggest potential new drug strategies that could prevent colon cancer by blocking the signal that activates c-MYC, says Kinzler, associate professor of oncology and director of the study. "Just eight years ago, we didn't even know about APC mutations. Now, we know this type of mutation is one of the earliest genetic changes in most colon cancers, and we know what it does to c-MYC. It's like a jigsaw puzzle. We have identified individual pieces of the cancer puzzle and now we can begin to put them together to see the whole picture of how they work together to cause cancer," Kinzler says.

Colon cancer, among the most common cancers in both men and women, this year will strike more than 131,000 Americans. Some 56,500 individuals will die of it.

In addition to Vogelstein and Kinzler, other research participants included Tong-Chuan He, M.D., Ph.D., Andrew B. Sparks, Ph.D., Carlo Rago, B.S., Heiko Hermeking, Ph.D., Leigh Zawel, Ph.D., Luis T. Da Costa, M.S., and Patrice J. Morin, Ph.D. The study was funded by the National Institutes of Health.

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Under a licensing agreement between the Johns Hopkins University and Genzyme, SAGE technology, which was used this study, is licensed to Genzyme for commercial purposes. Kenneth W. Kinzler, Ph.D., and Bert Vogelstein, M.D., are entitled to a share of the royalty received by the University from sales of the licensed technology. The SAGE technology is freely available to academia for research purposes. Kinzler and Vogelstein are consultants to Genzyme. The University and the researchers own Genzyme stock, which is subject to certain restrictions under University policy. The terms of this arrangement are being managed by the University in accordance with its conflict of interest policies.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FACSIMILE

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Ladies
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Deputy Chief of Staff

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COMMENTS:

Here is the colorectal cancer info. Please
consider it a draft. We need to ~~use~~
clarify a few points on the grants.

Have a great vacation!

1 Pages [including this cover]

DRAFT

FL- Sept 10

Colon Cancer

Possible Announcements from the National Cancer Institute

Screening: Research has proven that the fecal occult blood stool test, either annually or biennially, reduces mortality in people ages 50 to 80. Colorectal cancer is one of only three cancers where screening has been proven to reduce the death rate. The National Cancer Institute has research ongoing to see if screening use of flexible sigmoidoscopy also reduces deaths. Earlier evidence suggests that it does. In the future, a virtual colonoscopy would allow doctors to fly through a colon, searching for polyps and abnormalities without having to insert a scope in a patient's rectum. This technique is being studied and is not ready for application.

There is an urgent need to improve screening rates. When colorectal cancer is detected in an early, localized stage, the 5-year survival rate is 92%, but only 37% of colorectal cancers are detected that early. In 1992, only 30% of Americans over age 50 had a blood stool test in the past two years, and only 33% had a proctoscopic exam that year. A survey by the VA Medical Center in Durham, N.C., in 1995 found that respondents who had never been screened would forfeit a month of life to avoid a sigmoidoscopic (proctoscopic) exam.

New Finding: On September 4, NCI grantees at Johns Hopkins will publish a potentially landmark paper showing that mutations in the so-called APC gene are found in virtually all cases of colorectal cancer. The paper opens the door for followup work to determine how tests for the APC gene might be used to improve the early diagnosis of colorectal cancer. This is the first report of a "common genetic denominator" in colorectal cancer, meaning that there must be a mutation in the gene for colorectal cancer to occur. The September 10 event is close enough after the announcement of this finding that it could be referenced prominently as part of the progress being made against this disease.

Grants: The National Cancer Institute is awarding a nearly \$10 million, 5-year grant to the Fred Hutchinson Cancer Center in Seattle this week, and the announcement of this grant can easily be held until Sept. 10. The grant supports several basic research projects related to colorectal cancer and pancreatic cancer. The outcome of the studies could have impact on prevention and treatment of colorectal cancer. The chief investigator is Dr. John D. Potter.

Also, the National Cancer Institute's Epidemiology and Genetics Program has just completed awarding a group of seven grants, worth about \$4 million the first year. Six of the grants establish family registries in colorectal cancer and a seventh sets up an informatics center to track all of the data. Collectively, they will provide great insight into risk factors, both genetic and environmental, that are associated with colorectal cancer. The informatics center has just been established and the registries are just now beginning to collect family information. This has not been announced yet, and could be announced Sept. 10.

Finally, NCI's Epidemiology and Genetics Program just issued a request for grant applications to scientists all over the country to identify and evaluate the interactions of genetic and epidemiologic risk factors leading to cancer susceptibility. Colorectal cancer is included. NCI will commit \$5 million a year for 5 years to the effort. This can be announced also.

FL - Sept 10

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National Cancer Institute Research Accomplishments and Background Colorectal Cancer

- Colorectal cancer incidence dropped 2.3 percent per year from 1990 to 1995.
- Men showed the largest drops in incidence, 3.3% per year for white men and 2.5% for Asian and Pacific Islander men.
- White women had a 1.8% per year drop in incidence for this time period.
- Death rates for colorectal cancers dropped 0.9% per year during 1973 to 1990 and 1.5% per year from 1990 to 1995. Over the last 20 years, death rates have dropped 25 percent for women and 13 percent for men.
- The drops in colorectal cancer are not well understood. The use of fecal occult blood testing and sigmoidoscopy screening tests is low, signalling that factors other than screening are at play.
- An estimated 131,600 Americans will be diagnosed with colorectal cancer during 1998, 64,600 in men and 67,000 in women. It is the fourth most common cancer, accounting for 11% of new cancer diagnoses annually.
- About 56,000 Americans will die as a result of colon cancer this year.
- An estimated 1.2 million Americans currently are living with colorectal cancer, 599,000 men and 637,000 women; at least 1/2 were diagnosed at age 72 or older.

Accomplishments:

- Studies have shown that lifestyle factors may cause colorectal cancers, and that a diet high in fruits, vegetables and fiber and low in fat may reduce risk.
- Increased use of flexible sigmoidoscopy and colonoscopy, procedures that use lighted tools that illuminate the inside of the intestines, have made it simpler for doctors to remove abnormal growths before they turn into cancer.
- Researchers are developing 'virtual colonoscopy,' in which doctors use three-dimensional computer graphics to view the entire colon in less than 2 minutes, without the need for inserting a sigmoidoscope or colonoscopy.
- Doctors have found new drugs that work with fluorouracil (5-FU) to treat colorectal cancer better than 5-FU alone. Until the mid-1970s, 5-FU was the mainstay of drug treatment for these cancers.
- New surgical techniques have reduced to a small fraction the number of colorectal cancer patients needing permanent colostomy bags. Many post-surgery patients can now rely on simpler surgical 'flaps' on the side of the abdomen in place of colostomy bags.
- Doctors can now routinely test for genes in relatives of people who have rare inherited syndromes predisposing to colorectal cancer. Researchers are looking for similar tests for the more common colorectal cancers.

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Centers for Disease Control and Prevention

Colorectal Cancer: The Importance of Early Detection

Colorectal cancer is the second leading cause of cancer-related death in the United States. In 1998, approximately 131,600 new cases of colorectal cancer will be diagnosed, and an estimated 56,500 deaths will be caused by the disease. Although scientific evidence has proven that screening for colorectal cancer, along with appropriate treatment, can save lives, screening usage rates are low. Findings from the Centers for Disease Control and Prevention's (CDC) state-based Behavioral Risk Factor Surveillance System indicated that in 1995, only 38% of adults over age 50 had ever had a sigmoidoscopy for screening or diagnostic purposes, and 29% of respondents reported having had one within the past 5 years. In the 1992 National Health Interview Survey, 48% of adults aged 50 and over reported ever having had a fecal occult blood test, and only 17% reported having had one for screening in the preceding year. These low rates of screening usage point to the fact that health care providers and the public have not yet grasped the importance of early detection.

The CDC provides leadership in developing a national strategy to educate health care providers and the public about colorectal cancer screening guidelines and the availability of screening procedures as part of a comprehensive approach to cancer prevention and control. CDC focuses on a three-pronged approach to developing a colorectal cancer early detection program involving:

- ▶ research—to establish the foundation for a science-based early detection program
- ▶ education—to increase the awareness of the importance of early detection
- ▶ partnerships—to support this critical public health priority

• Research studies and special projects

CDC provides support for a number of studies to determine barriers to screening and determinants of participation in screening, as well as research to develop standards for performing and reporting results of sigmoidoscopies. CDC will use findings from these studies to translate research into effective public health education and communication strategies for raising provider and public awareness about the need for colorectal cancer screening.

- ▶ CDC provides support for two multiyear studies, one with Kaiser Permanente Medical Care Program of Northern California and another with the Imperial Cancer Research Fund in Great Britain, to determine patients' interest and participation in sigmoidoscopy screening.
- ▶ CDC works with The HMO Group to validate self-reported history of colorectal cancer screening by comparing responses to a telephone survey to information recorded on medical charts for a sample of adults aged 50 and older.
- ▶ CDC works with the ACS and National Cancer Institute (NCI) to plan a national survey of primary care physicians to determine their knowledge, attitudes, and perceptions of barriers to colorectal cancer screening. In addition, CDC's National Center for Chronic Disease Prevention and Health Promotion is collaborating with CDC's National Center for Health Statistics and the NCI to strengthen and expand the colorectal cancer screening questions that will be included in supplements to the National Health Interview Survey.
- ▶ CDC collaborates with the Mount Sinai School of Medicine, New York, to conduct a study of attitudes, beliefs, and practices related to colorectal cancer. Similarly, CDC is providing support for Memorial Hospital of Rhode Island to identify sociocultural and psychological influences affecting Hispanics' beliefs, attitudes, and practices associated with cancer prevention, including colorectal cancer screening. In addition, the study will assess providers' perceptions of Hispanic patients regarding cancer prevention and screening.
- ▶ CDC provides support for a 3-year program at the University of North Carolina Prevention Center to develop standards for performing and reporting results of sigmoidoscopies.

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- ▶ In 1993, the NCI initiated a 15-year randomized control trial of screening for prostate, lung, colorectal, and ovarian cancers (PLCO). CDC collaborates with NCI to enhance recruitment of African American males for participation in this trial. The focus of the colorectal cancer screening in the PLCO trial is flexible sigmoidoscopy.
- ▶ CDC collaborates with the Group Health Cooperative of Puget Sound on a study of preventive services for older women. The study includes surveys of female members aged 50 or older and of providers to determine their knowledge, attitudes, and practices related to screening for colorectal cancer.

● Education Efforts

- ▶ CDC is working with the Health Care Financing Administration (HCFA) to promote Medicare's new 1998 colorectal cancer screening benefits and to encourage eligible beneficiaries to take advantage of this potentially life-saving screening test. These efforts are part of CDC's larger communication initiative to promote colorectal cancer screening among Americans aged 50 and older. On the basis of extensive literature review, research, and qualitative testing, CDC is planning a targeted public education campaign to promote screening for colorectal cancer. This campaign is tentatively scheduled to begin in late winter 1998-1999.
- ▶ Through the National Organizations Partnership for Cancer Control among Priority Populations, CDC provides support to the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO) to develop a National Hispanic Colorectal Cancer Outreach and Education Project, addressing the need for increased awareness of and screening for colorectal cancer among Hispanics.

● Partnerships

In addition to its collaboration with HCFA to promote Medicare coverage for colorectal cancer screening, CDC is building other partnerships to strengthen the network of public and private organizations concerned with promoting colorectal cancer early detection:

- ▶ The CDC and the American Cancer Society (ACS) have collaborated to establish the **National Colorectal Cancer Roundtable**—a coalition of public, private, and voluntary organizations—to educate health care providers and the public about the importance of colorectal cancer screening. The ultimate goal of the Roundtable is to increase use of proven colorectal cancer screening tests among the entire population for whom screening is appropriate. The Roundtable has established specific workgroups to make recommendations for addressing education needs and health messages for both patients and health care providers, as well as health care system and policy issues.
- ▶ During fiscal year 1999, CDC plans to provide support for up to five states to promote colorectal cancer early detection as part of a comprehensive cancer control approach.

The development and implementation of an effective national colorectal cancer screening program is contingent upon the capacity of state health departments, in collaboration with governmental, professional, and voluntary partners, to build the public health infrastructure to support the delivery of these critical screening tests to underserved men and women. This national program must be supported by a solid research base and should include the following essential elements: public and professional education, coalition building, quality assurance, surveillance, and evaluation. With additional resources, CDC could lay the foundation for a national colorectal cancer screening program by supporting state health departments to effectively address the barriers that impede the implementation of a national early detection program for colorectal cancer and provide access to screening services for underserved populations.

For more information, contact Louise Galaska, MPH, Acting Director,
CDC's Division of Cancer Prevention and Control
(770) 488-4226

DRAFT

**** CENTERS FOR DISEASE CONTROL AND PREVENTION ****

National Colorectal Cancer Roundtable

The Centers for Disease Control and Prevention (CDC) is collaborating with the American Cancer Society (ACS) to establish a **National Colorectal Cancer Roundtable**. The Roundtable is a national coalition of public, private, and voluntary organizations whose mission is to identify barriers to screening for colorectal cancer, assess current public awareness of and interest in screening, and develop and disseminate health messages. The ultimate goal of the Roundtable is to increase the use of proven colorectal cancer screening tests among the entire population for whom screening is appropriate. In addition to CDC and ACS, members of the Roundtable include:

- ** federal agencies (National Cancer Institute, Agency for Health Care Policy and Research, and Health Care Financing Administration),**
- ** New York State Health Department**
- ** professional digestive disease organizations (American Digestive Health Foundation, Digestive Disease National Coalition, Stop Colon/Rectal Cancer Foundation),**
- ** medical societies (American Medical Association, National Medical Association, American Academy of Family Physicians, American College of Physicians, American Medical Women's Association, American College of Radiology, American Society of Colorectal Surgeons),**
- ** consumers (American Association of Retired Persons, National Caucus and Center on Black Aged),**
- ** cancer survivors (to be added),**
- ** managed care organizations (The HMO Group, American Association of Health Plans), and**
- ** health educators (Association of State and Territorial Directors of Health Promotion and Public Health Education).**

The Roundtable has established three specific workgroups, focusing on Provider Education, Public Education, and Health Policy, to address education needs and health messages for both consumers and health care providers, as well as health care system and policy issues. Each workgroup will be charged with developing a set of recommendations that will be integrated with those of the other workgroups into a *national colorectal cancer strategic plan*.

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In addition to involving many Roundtable members, the workgroups will include other organizations and experts currently being identified, such as the United Ostomy Association, Crohn's and Colitis Foundation of America, Kaiser Permanente, National Committee for Quality Assurance, American College of Gynecology, American College of Gastroenterology, M.D. Anderson Cancer Center, and Industries Coalition Against Cancer. Other organizations and individuals will be invited to join, or to consult with, the workgroups as needed.

Many challenges and needs have already been noted by the **National Colorectal Cancer Roundtable**, including identifying "best practices" for colorectal cancer programs, emphasizing the importance of follow-up and treatment, and determining where colorectal cancer activities correlate with other comprehensive cancer control and chronic disease priorities. There is clearly a need to elevate colorectal cancer as an important health focus among the public, health care providers, and policymakers. The potential public health benefits from establishing a national colorectal cancer early detection program are widely recognized.

Collaborations with state health departments are critical in advancing effective public health programs. A number of states, in fact, have already taken steps to incorporate colorectal cancer activities in their cancer control plans. The development and implementation of an effective national colorectal cancer screening program is contingent upon the capacity of state health departments, in collaboration with governmental, professional, and voluntary partners, to build a public health foundation to support the delivery of these critical screening tests to underserved men and women.

Combating this major cancer killer requires a concerted national effort. **Roundtable** Workgroups are focusing on the development of a national colorectal cancer strategic plan for increasing use of screening; a number of state health departments and other partners are planning and implementing colorectal cancer activities. These combined efforts are critical for establishing the foundation for an effective national colorectal cancer screening program.

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cancerinfo@cdc.gov
<http://www.cdc.gov/nccdphp/dcp>

6

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WHSO Layout Draft 3
a/o 9/8/98; L. Schwartz

GOOD HOUSEKEEPING COLON CANCER PREVENTION EVENT
Thursday, September 10, 1998

East Room Event
State Dining Room Reception

EV Gate Opens:	2:30 p.m.		
Invite Time:	3:00 p.m.		
Principal Time:	3:00 p.m.	Brief	Elevator, State Floor
	3:05 p.m.	Meet	Red Room
	3:15 p.m.	Meet	Blue Room
	3:25 p.m.	Event	East Room

Approx. 160?/Open Press/Business Attire
10 Social Aides

- Marsha: NW Gate:
- Meet Katie Lounic:
- ~~2~~ ¹ corporal
- Debbie - g: Ellen spouse

→ Good Housekeeping -
Ellen Levine:
→ Chicago - 2 yrs.

- Elizabeth Ely:
find out if she's
coming.

→ Cybercast:
→ what it is, briefly → ok -
to toward in blue room

192 briefly welcome

SET UP NOTES GROUND FLOOR: coat check in family theater
GRAND FOYER/STATE FLOOR: string combo with piano in Grand Foyer; 1 easel in Grand Foyer for Good Housekeeping cover - 30x40
EAST ROOM/EVENT: 10x16 stage at gold curtain; Toast lectern in East Room; WHCA Announce from Blue Room; water at podium; 2 Press risers on both sides of cross hall doors; 2 50inch monitors placed on floor on both sides of stage in East Room for play of psa during event; lights provided by residence electricians; programs on chairs.
BLUE ROOM MEET: furniture removed from Blue Room for meet and greet; WHCA announce for program.
GRAND FOYER: stand up reception - tea and pastries; string combo will play for reception.
BOOK SELLERS: one table with cloth and flowers for distribution of Good Housekeeping October issue distribution on departures.

WEDNESDAY, September 9

2:00 p.m. Future View Video monitor set up for event.

THURSDAY, September 10

12:00 p.m. Future View returns for video check/final set up.

2:15 p.m. IN PLACE TIME

2:30 p.m. East Visitors Gate opens and guests proceed to the State Floor and are seated in the East Room.

3:00 p.m. **THE FIRST LADY** arrives elevator on State Floor and is briefed.
Contact: Jennifer Klein/Neera Tanden

3:05 p.m. **THE FIRST LADY** proceeds to the Red Room for a private meet with Katie Couric and family.

3:15 p.m. **THE FIRST LADY** proceeds to the Blue Room to meet other event participants and corporate commitment representatives (approx. 20 total).

3:25 p.m. **THE FIRST LADY** is announced into the East Room accompanied by Secretary Donna Shalala, Good Housekeeping Editor Ellen Levine, NBC Today Show host Katie Couric and Dr. Bernard Levin.

PROGRAM BEGINS

THE FIRST LADY briefly welcomes guests to the White House and introduces Secretary Shalala.

Secretary Shalala makes remarks and introduces Ellen Levine.

Ellen Levine makes remarks and introduces Katie Couric.

Katie Couric makes remarks and introduces Dr. Bernard Levin.

Dr. Levin makes remarks, introduces the PSA and **THE FIRST LADY**.

THE FIRST LADY returns to the podium to make substantive remarks.

4:00ish p.m. The program concludes and **THE FIRST LADY** invites guests into the Grand Foyer for tea and pastries.

NOTE: Optional receiving line following event. The flow would be as follows: Guests move from the East Room, through the Green, into the Blue and out the Red and into a reception in the Grand Foyer.

THE FIRST LADY has the option to proceed to the Grand Foyer or depart to the Residence.

Following the tea, guests depart East Gate.

30 Rockefeller Plaza
New York, NY 10112
212 664-4444

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TODAY SHOW

FAX COVER SHEET

TO: Neera

FROM: Jay Richter

RE: Katie's final draft.

#PAGES INCLUDING COVER 4

kcouric Thu Sep 10 11:00 page 1

SLUG	SHOW	WRITER	MODIFIED	kcouric	TIMING	LC
WHITE HOUSE REMARKS	REVISED	kcouric	Thu Sep 10 10:10 1998	HOLD	4:00	124

=====

THANK YOU ELLEN.

I WISH I COULD SAY I'M HAPPY TO BE HERE ON THIS OCCASSION, AS MANY OF YOU KNOW THAT COULDN'T BE FURTHER FROM THE TRUTH. BUT I AM SO GRATEFUL TO MRS. CLINTON FOR HER INTEREST AND COMMITMENT, TO ELLEN LEVINE AND THE STAFF OF GOOD HOUSEKEEPING FOR THEIR INCREDIBLY THOROUGH COVERAGE IN THEIR UPCOMING OCT. ISSUE AND THE TODAY SHOW PRODUCERS AND STAFF FOR WHAT I HOPE WILL BE A LIFE-SAVING SERIES ON COLON CANCER THAT WILL AIR NEXT WEEK.

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I SUFFERED A VERY PERSONAL LOSS, ONE THAT I DEAL WITH EVERY MINUTE OF EVERY DAY. JAY WAS A GIFTED, HIGHLY INTELLIGENT MAN OF COMPASSION AND INTEGRITY...WITH EVERYTHING TO LIVE FOR, INCLUDING TWO ADORED AND ADORING

kcouric

Thu Sep 10 11:00 page 2

DAUGHTERS. A LIFE CUT SHORT IS SO UNNATURAL. AND FRANKLY, I'M STILL IN THE ANGER STAGE, IN FACT, I'M MAD AS HELL. I'M ANGRY THAT THE FIRST LINE CHEMOTHERAPY FOR COLON CANCER, WHICH HAS ONLY A MODEST RESPONSE RATE, HAS BEEN AROUND SINCE THE 1950'S. I'M ANGRY THAT DESPITE THE FACT THAT 13,000 PEOPLE UNDER 50 ARE DIAGNOSED WITH THIS DISEASE EVERY YEAR, THESE PEOPLE ARE COMPLETELY IGNORED: MOST DOCTORS DON'T CONSIDER IT A POSSIBILITY, AND EVEN DISMISS SYMPTOMS AS HEMMORHOIDS...UNTIL IT'S TOO LATE.

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kcouric

Thu Sep 10 11:00 page 3

MADE A DIFFERENCE.

IT'S MY PLEASURE TO INTRODUCE SOMEONE WHO CARES DEEPLY ABOUT HEALTH CARE,
PREVENTION, AND MOST OF ALL PEOPLE. FIRST LADY HILLARY RODHAM CLINTON.

30 Rockefeller Plaza
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TODAY SHOW

FAX COVER SHEET

TO: NEERA TANDEN

FROM: JOY RICHTER

RE:

#PAGES INCLUDING COVER 4

jrichter

Thu Sep 10 09:34 page 1

SLUG	SHOW	WRITER	MODIFIED jrichter	TIMING LC
WHITE HOUSE REMARKS	REVISED	kcouric	Wed Sep 9 21:17 1998 HOLD	3:53 120
=====				

THANK YOU ELLEN.

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jrichter

Thu Sep 10 09:34 page 2

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jrichter

Thu Sep 10 09:34 page 3

PREVENTION, AND MOST OF ALL PEOPLE. FIRST LADY HILLARY RODHAM CLINTON.



CUSTOMER NBR: 1695000023

RPOIYH

PAGE: 01

TO: WHITE HOUSE TRAVEL
1600 PENNSYLVANIA AVE
WASH DC 20500

FOR: SPERLING/GENE

14 SEP 98 - MONDAY
AIR DELTA AIR LINES INC FLT:1757 COACH SNACK/BRUNCH
LV NEW YORK LGA 230P EQP: 727 STRETCH
DEPART: MARINE AIR TERMINAL 58MIN
AR WASHINGTON REAGAN 328P NON-STOP
ARRIVE: TERMINAL B/C REF: R9QNJ5

19 MAR 99 - FRIDAY
OTHER WASHINGTON
THIS DATE IS FOR AMERICAN EXPRESS HISTORICAL DATA ONLY.

. TOTAL AIRFARE USD57.00
AIR FARE SUBJECT TO CHANGE. PLEASE CALL FOR CORRECT
FARE BEFORE PROCESSING TRAVEL AUTHORIZATION.
SECURITY ALERT INFORMATION
DUE TO THE FAA MANDATED INCREASE IN AIRPORT SECURITY
YOU MAY BE REQUIRED TO PRODUCE A PHOTO IDENTIFICATION
AT AIRPORT CHECKIN.
FOR AFTER HOUR EMERGENCIES
CALL 800-847-0242/YOUR HOTLINE CODE IS S-KC52

. REMINDER
ALL FREQUENT FLYER BENEFITS EARNED ON OFFICIAL TRAVEL
ARE THE SOLE PROPERTY OF THE U.S. GOVERNMENT AND CANNOT
BE REDEEMED FOR PERSONAL USE.

. ALL UNUSED TICKETS ARE TO BE RETURNED TO AMERICAN
EXPRESS OR YOUR TRAVEL COORDINATOR IMMEDIATELY UPON
RETURN FROM TRAVEL OR WHEN TRIP HAS BEEN CANCELED.

. THANK YOU FOR TRAVELING WITH AMERICAN EXPRESS.

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New York, NY 10112
212 664-4444

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TODAY SHOW FAX COVER SHEET

Christy
x 65709

TO: Neera Tanden 202-456-7805
Toby 202-456-2878

FROM: Joy Richter

RE:

Katie Couric Remarks
+ TODAY SHOW SERIES OUTLINE

#PAGES INCLUDING COVER 5

jrichter

Wed Sep 9 14:40 page 1

SLUG	SHOW	WRITER	MODIFIED jrichter	TIMING	LOC
WHITE HOUSE REMARKS		kcouric	Wed Sep 9 14:40 1998 HOLD	3:58	120
=====					

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jrichter

Wed Sep 9 14:40 page 2

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jrichter

Wed Sep 9 14:40 page 3

PREVENTION, AND MOST OF ALL PEOPLE. FIRST LADY HILLARY RODHAM CLINTON.

American
Digestive
Health
Foundation



Facsimile Cover Sheet

ADHF, 7910 Woodmont Ave., Suite 700, Bethesda, MD 20814

To: Neera Tanden

From: Carole Anikis

Company: American Digestive Health Foundation

Phone: (301)941-2626

Fax: (301)654-5920

Email: canikis@gastro.org

Date: September 9, 1998

**Pages including 5
this cover page:**

Neera:

Here are Bernard's remarks, incorporating your changes, and the changes to the speaking order. He hasn't seen them yet, but we'll tell him he can't make substantial changes!

**Remarks by Dr. Bernard Levin
White House Event
September 10, 1998**

Thank you, Secretary Shalala. Good afternoon Mrs. Clinton. Good afternoon ladies and gentlemen. I am Dr. Bernard Levin, vice president for cancer prevention at the University of Texas M.D. Anderson Cancer Center, and chair of the National Colorectal Cancer Roundtable. Recently founded by the American Cancer Society and the Centers for Disease Control and Prevention, the Roundtable is a coalition of 25 medical professional, consumer advocacy and voluntary organizations, many of which are represented here this afternoon. Our mission is to reduce the suffering and mortality from this disease by achieving screening rates for colorectal cancer that are equivalent to those for other cancers. Currently, for example, four out of five people are screened for breast and cervical cancer. Colorectal cancer screening rates are nowhere near that and we need to be.

We've all heard the old saying, "an ounce of prevention is worth a pound of cure." As a practicing physician who specializes in colon cancer, I

Levin/2

can tell you that nothing is more true of this disease. From where I sit, the real tragedy of 50,000 deaths a year from colorectal cancer is that so many of them can be prevented. I have sat by the bedsides of too many patients with this cancer, and have sympathized with too many family members who have lost loved ones to this disease, simply because they were not screened.

Colorectal cancer is preventable. Moreover, colorectal cancer is curable when detected early. In fact, if we instituted widespread screening for the disease as a national priority, we could reduce the death rate by at least 50 percent. There is no other disease about which we can make this claim.

Sadly, too many people are not getting this message, even from their physicians. The number of doctors who fail to recommend screening for their patients over age 50 is alarming. Physicians must make screening for colorectal cancer a routine part of their practices. General practitioners,

Levin/3

family doctors, internists, gynecologists – all must inform their patients over 50 of the benefits of screening and urge them to get tested. In fact, better education of physicians is a primary goal of the National Colorectal Cancer Roundtable. Medicare now reimburses the cost of screening for those over age 65 – a wise decision by the Administration and Congress.

In addition to screening, lifestyle choices can help to prevent colorectal cancer. Eating plenty of vegetables and high fiber foods, as well as exercising regularly, can lower your risk. And know your family history. People with a close relative who has had colorectal cancer are at higher risk of developing the disease themselves, and should start screening earlier.

In keeping with our efforts to get these messages out, I am pleased now to unveil a new public service announcement campaign, starring the First Lady. The National Colorectal Cancer Roundtable is grateful that Mrs. Clinton is taking this leadership role in the fight against colorectal cancer,

Levin/4

and we are honored that she serves as our Honorary Chair. We are also very excited that NBC network has agreed to air the public service announcement you are now about to see. Please look to the monitors on either side of the room.

[play PSA]

I am pleased now to introduce the Editor-in-Chief of *Good Housekeeping* magazine, which will publish Mrs. Clinton's print public service announcement in its January issue. Ladies and gentlemen, Ellen Levine.

Good Housekeeping

959 EIGHTH AVENUE, NEW YORK, NY 10019 * 212-649-2200 * FAX 212-265-3307

September 4, 1998

TO: Neera Tanden

FROM: Debbie Pike

RE: Ellen Levine's remarks for colon cancer event

Today is an important day; it marks the beginning of a new public health campaign that has the power to save thousands of lives. Good Housekeeping believes we must start talking about colon cancer. Women have always used their personal experiences to raise public awareness of disease and save the lives of their families and friends. It's really easy to forget that thirty years ago, no one talked about breast cancer. It was embarrassing. It was the C-word. But when former First Lady Betty Ford spoke out about her breast cancer diagnosis, other well-known people followed. Then, slowly, women began to get mammograms, though not enough doctors were encouraging it--despite the fact that science was beginning to show that routine testing could save lives. Just ten years ago, only 27 percent of women age 50 and over were being tested. Today, that number has more than doubled--at least 60 percent of women age 50 and over are getting screened. And there's been a substantial decline in deaths from breast cancer--the largest drop since 1950. How did this happen? In no small way, thanks to women's voices, the famous and the not-so-famous, talking out loud about taking care of themselves and raising our awareness of breast cancer.



Now it's time for women to speak out about colon cancer. I became too aware of the disease. Many dear friends have been diagnosed with it. This year, colon cancer will claim the lives of more women than men--primarily because women aren't being screened. There are many reasons for this: Women wrongly believe colon cancer is a man's disease; our doctors don't insist we be tested; or we're too afraid or embarrassed. Even I, who should know better, postponed screening until January of this year, just because I thought it was going to be unpleasant. That's a tragedy, because screening has been proven to save lives.

We at Good Housekeeping want to spread the word, so we've devoted a section of our October Issue to what women can do to protect themselves. Experts told us over and over again that early detection is key. At least one woman in the audience today is living proof of that message. Last March, Elizabeth Ely, a 55-year-old interior decorator in New York City, decided to have a colonoscopy, a test that allows a doctor to check the entire colon for abnormalities. Her physician had urged her to get screened because of her age. After the test, she was shocked to learn she had a malignant rectal tumor. Fortunately, it was an early-stage cancer, and surgery cured her. But her experience was a real wake-up call.

In our efforts to raise awareness of colon cancer, we turned to Katie Couric, a very brave woman and brilliant newscaster. All over America, people tune in to the Today Show and recognize Katie as a friend, daughter, sister or mother. And all over America, we are

aware that her leadership on this issue has come the hard way.

Women like Katie take their responsibilities not just to their families but to their public with a seriousness. She knows a lot more ~~about this disease than many doctors, and she's convinced that~~ *stet* our ~~ability to talk openly about colon cancer will simply save lives.~~

Now I'd like to introduce a woman I consider a good friend and one of the great voices of our time: Katie Couric, anchor of the Today Show.



FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

*These
have
subs
changed*

DATE: 9/4/98

TO: Nesra

FAX: 202-456-2878

PHONE: _____

FROM: H. Lavine

Phone: (202)

Fax: (202)

TOTAL NUMBER OF PAGES TRANSMITTED: 4

COMMENTS:

*Nesra,
If you need to talk to
anyone about this
tomorrow, please
call Jeff Denny at 690-7470
The Sec. has signed
off on this.
Thank for your patience
Howard*



U.S. Dept. of Health and Human Services
Office of the Secretary

HOWARD D. LAVINE
Speechwriter

Room 629E, H. H. Humphrey Bldg.
200 Independence Avenue, S.W.
Washington, DC 20201

(202) 690-7470
Fax (202) 690-7318

200 Independence Avenue, S.W., HHH Bldg., Room 638-E, Washington, D.C. 20201

Thank you Mrs. Clinton. Ms. Couric, Ms. Levine, Dr. Levin [pronounced Levine], distinguished guests.

Yesterday, in his speech to schoolchildren in Orlando, the President made an interesting observation about the new king of swing, Mark McGwire.

He said that although McGwire has made home-run history, he's not going to quit baseball or take walks.

He's going to keep suiting up, staring pitchers down, and swinging for the fences.

Because that's what heroes do, no matter what their walk of life.

And that's what we need to do in the battle against Cancer

Many of my heroes are in this room – physicians, researchers, foundation leaders who helped build a cancer detection and prevention strategy.

And they join other heroes in the fight against cancer: the President and First Lady; scientists at NIH, FDA, CDC and research institutes and universities around the world; Congress that appropriated funds, and, of course, patients and their families.

Together, these heroes have helped win many victories.

Overall cancer rates are down.

New drugs are coming on the market that prevent some breast cancers.

Public awareness about the importance of cancer prevention is on the rise.

But just as Mark McGwire won't start taking walks, we won't walk away from this fight. And that's why we're here today – to strike out colorectal cancer.

Although many Americans don't know it, colorectal cancer is one of our nation's biggest killers.

It often strikes in the prime of life – and hits men and women almost equally.

And most important, although it tends to run in families, no one is immune.

This is a seemingly bleak story. But turn the page because behind it is a story of discovery, change and hope.

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We know that a high-fiber, low-fat diet cuts the risk of this terrible disease.

And we've discovered a genetic marker that make critical early detection easier.

Research proves that a special test for colorectal cancer – just once a year – reduces the chance of death in people 50 to 80.

And the examinations are getting easier as new diagnostic equipment makes screenings quicker and less painful.

So our message is unmistakable. Eat smart. Know your family history. And get a regular screening after age 50.

That's a message that the National Colorectal Cancer Roundtable – with major help from the CDC – is bringing to homes across America.

Roundtables are like great baseball teams. Everyone is necessary, but there will always be a Mark McGwire – or a King Arthur – leading the charge.

The head of the National Colorectal Cancer Roundtable has that kind of extraordinary leader of vision and courage..

So I'm proud to introduce a knight in shining armor for every American fighting colorectal cancer, Dr. Bernard Levin. Bernard . . .

September 8, 1998

PROMOTING PREVENTION AND EARLY DETECTION OF COLORECTAL CANCER

DATE:	September 10, 1998
TIME:	3:00 pm
LOCATION:	The East Room, The White House
FROM:	Jennifer Klein Neera Tanden

I. PURPOSE

To raise awareness about colon cancer and the importance of early detection through proper screening. You will announce a series of initiatives to prevent colon cancer. You will also release a new survey reporting that only half of all Americans over 50 are screened for colon cancer and that most Americans are not aware of the importance of early detection and prevention.

II. BACKGROUND

Overview:

You will make a series of announcements designed to raise awareness of colon cancer and to promote prevention. Your involvement in this event will spotlight a disease that has had little attention in the past. This event arose, in part, from the interest of Katie Couric, anchor of the "Today Show," and Ellen Levine, Editor-in-Chief of "Good Housekeeping"; and Katie Couric, Anchor for the "Today Show."

As part of its own efforts to raise awareness, "Good Housekeeping" Magazine is initiating a colon cancer awareness campaign in its October issue. The magazine, in collaboration with Katie Couric, is featuring a medical report on how women can prevent colon cancer. "Good Housekeeping" will also suggest that private insurance companies cover colonoscopy screening tests for people over age 50.

"The Today Show" will present a week-long in-depth series, "Confronting Colon Cancer," that will offer a comprehensive look colon cancer, starting Monday, September 14th. Katie Couric will host the five-part series that will cover a variety of topics, including: what colon cancer is, how it can be prevented, and the various screening methods and post-operative treatments available. The series will close with a discussion of new therapies and an exploration into the possibility of a cure in the future.

NEW ANNOUNCEMENTS:

Health and Human Services Grant

You will announce an \$8 million grant by the National Cancer Institute to the Seattle Gastrointestinal Program Project for research aimed at preventing, diagnosing and treating colon cancer. The grant will help scientists identify new ways of monitoring people at risk for colon cancer and test new strategies to reduce their cancer risk. The grant will also be used to develop more sensitive and precise ways of screening colon cancer than those available today.

Colon Cancer Roundtable

You will also announce an unprecedented private and public sector partnership to promote greater awareness of colon cancer -- the National Colorectal Cancer Roundtable. Group members include the Centers for Disease Control, the American Cancer Society, and the American Digestive Health Foundation. [See attachment on Roundtable] This organization has recently been formed to promote prevention, and is particularly focused on educating physicians and other health professionals on the importance of screening and early detection.

National Survey Highlights the Need For Early Detection

You will announce the results of a new national survey that reveals that nearly half of adults aged 50 and older -- the age group considered at highest risk for developing colon cancer -- have not been screened for the disease. According to the survey, 47 percent of the people over 50 who had never told by a medical professional to be tested. Forty-nine percent of women were never screened compared to 36 percent of men. Also, non-whites were less likely to have been screened than whites. The majority of adults surveyed believed that early detection was beneficial, but many did not know what they could do to help prevent colorectal cancer. The poll was conducted by the Gallup Organization for the Colorectal Cancer Roundtable and surveyed 1,062 adults aged 50 and over.

Public Service Announcements

The Colorectal Cancer Roundtable sponsored a public service announcement campaign as part of their new initiative to promote prevention and early detection of colorectal cancer. You are featured in the announcement that urges all Americans over the age of 50 to be screened for colorectal cancer. Dr. Levin will introduce the PSA as part of his remarks. NBC has already committed to airing the PSA, possibly on the "Today Show," and the print version will appear in the January issue of "Good Housekeeping."

Colorectal Cancer Chat Room

You will also announce a new Internet "chatroom" that will allow consumers, patients, family members, survivors, and people at high risk for the disease to engage in live discussions of issues relating to colorectal cancer. Doctors and other experts will be available on line to answer questions about this disease. The website address is www.gastro.org/adhf.html, and will be sponsored by the American Digestive Health Foundation, a member of the Colorectal Cancer Roundtable.

Private Sector Partnerships

You will also announce new commitments by the private sector to help increase awareness about the importance of colorectal cancer prevention and early detection.

- American Airlines will publish the public service announcement on colon cancer in its in-flight magazine, *American Way*, where it may reach approximately two million travelers in the U. S. and abroad.
- The Kellogg Company will promote colon cancer prevention and early detection by printing public service messages on five million packages of All Bran and Bran Buds cereals.
- The National Association of Chain Drug Stores will distribute an insert created by American Greetings about prevention and early detection to all of its pharmacies and pharmacists.
- Bristol-Myers Squibb Oncology has provided a \$100,000 grant to the Better Health Foundation to develop a colon cancer workplace awareness program that it will initiate at all of its work sites.
- Olympus America, Inc., will sponsor an education program on colon cancer that will be sent to the administrators of retirement communities all across the country.
- General Motors will publish an article in its newsletter to encourage its 2 million employees to research information relating to preventing, detecting and understanding colorectal cancer.
- Other private industries included in the partnership are Beckman Coulter/ SmithKline Diagnostics, Eli Lilly and Company, and Zeneca Pharmaceuticals, all of whom have committed to raise awareness among their employees.

BACKGROUND ON COLON CANCER

Colon cancer, which is often described as colon cancer in the medical community, is the number one non-tobacco-related cancer killer; more than 50,000 Americans die each year from the disease. For both men and women, it is the third most common cancer, and 130,000 Americans contract the disease each year. Men and women over the age of 50 have the greatest risk of developing colon cancer. However, it is preventable and curable when detected early; in fact, a patient whose cancer is detected early has more than a 90 percent chance of survival.

In addition, the nature of colon cancer makes it especially difficult to detect. Most colon cancers are “silent” tumors; they grow slowly and often do not produce any noticeable symptoms until they reach a large size. Recent studies show that screening can reduce a person’s risk of colon cancer by as much as 90%. Currently, the CDC recommends screening for colon cancers, especially for those individuals over the age of 50. There are three tests used in screening for colon cancer. The fecal occult blood testing (FOBT) is least invasive and costs as little as \$10. Two more thorough and invasive screening methods, the flexible sigmoidoscopy and colonoscopy, can cost as much as \$2,000; and, unfortunately, many insurance companies do not cover the cost of these tests.

Administration Accomplishments

Under the 1997 Balanced Budget Act, Medicare covers the FOBT, flexible sigmoidoscopy and screening colonoscopy for high-risk individuals; this benefit became available for 37.3 million

Americans on January 1, 1998. The Secretary of HHS was also given authority to allow Medicare coverage of other screening tests as they become available.

According to the National Cancer Institute and the Center For Disease Control and Prevention, the federal government appropriated roughly \$99 million for colon cancer research and \$2.5 million for prevention in 1997. In comparison, the government allocated \$332.9 million on breast cancer research, \$145 million on breast cancer prevention and \$123.3 million on lung cancer research in 1997.

III. PARTICIPANTS

Meet and Greet

Nestor Kowalsky, Central Regional Medical Director, American Airlines
Deborah Dingell, General Motors Industry
Karen Kafer, Director, Communications, Kellogg USA
Janine Nessit, Better Health Foundation (on behalf of Bristol Myers Squibb Oncology)
Louis Costentio, Vice President, Endoscope Division Manager, Olympus America
James Schlicht, Vice President, Government Relations, Zeneca Pharmaceuticals
William Pelzer, Jr, President, SmithKline Diagnostics, Beckman Coulter, Inc.
Gregory Larkin, MD, Director, Corporate Health Services, Eli Lilly
Deborah Hohit, Director, Public Affairs, Eli Lilly
Phillip Schnieder, National Association of Chain Drug Stores
Jill Froula, American Greeting
Amy Manela, Program Director, American Digestive Health Foundation
Gerald L. Woollam, MD, American Cancer Society, (Dr. Woollam will present you with a small glass award you that will be engraved "to Hillary Rodham Clinton for her outstanding work in cancer, September 10, 1998")
Dr. Bernard Levin, Vice President, MD Anderson Cancer Center
Ellen Levine, Editor-in-Chief of "Good Housekeeping"

Speaking Program Participants

-First Lady Hillary Rodham Clinton
-Secretary Donna Shalala
-Bernard Levin, MD, chair, National Colorectal Cancer Roundtable
-Ellen Levine, Editor-in-Chief of Good Housekeeping
-Katie Couric, co-anchor of the Today Show

Audience

Amongst the 180 guests in the audience, 4 reporters have accepted: Matt Lauer (NBC), David Bloom (NBC), Tamara Jones (Wash Post) and Barbara Harrison (WRC/DC).

This event will be broadcast live on the Internet on the American Cancer Society website.

IV. SEQUENCE OF EVENTS

- The First Lady joins Katie Couric in a private meeting in the Red Room.
- The First Lady then takes part in a meet and greet in the Blue Room with corporate representatives and panel participants.
- The First Lady proceeds to the speaking program in the East Room.
- The First Lady introduces Secretary Donna Shalala.
- Secretary Shalala makes brief remarks and introduces Dr. Bernard Levin
- Dr. Bernard Levin makes brief remarks, shows the PSA, and introduces Ellen Levine.
- Ellen Levine, Editor-in-Chief of Good Housekeeping, makes brief remarks and introduces Katie Couric.
- Katie Couric makes brief remarks and introduces the First Lady.
- The First Lady makes remarks and then welcomes the audience to join her for a reception in the Grand Foyer.

V. REMARKS

Provided by Christy Macy.

neera/Jenn

HILLARY RODHAM CLINTON
COLON CANCER GOOD HOUSEKEEPING EVENT
THE WHITE HOUSE
SEPTEMBER 10, 1998

Welcome to the East Room and the White House. It's a pleasure and honor to have all of you here with us today, as we send out a loud and powerful message to the American people: Colon cancer is the second most deadly cancer there is -- claiming more than 50,000 lives every year. But it's a disease we can fight -- and beat -- if it's detected early. Today, we come together to launch a national effort to raise public awareness and promote early detection of this terrible -- but preventable -- disease. We are here -- quite simply -- to help save lives.

Before we begin our program, I want to say that none of us would be here today -- nor would we be so far along in our efforts to combat colon cancer -- without the bravery, commitment, and leadership of many of the people in this room. A very special welcome to Katie Couric -- who has endured such a deep personal loss with enormous courage and grace. We are all indebted to her for bringing national attention to the issue of colon cancer and how to prevent it. And just a few weeks ago, I joined Ellen Levine [LAVEEN] -- Editor-in-chief of Good Housekeeping magazine -- in Russia, at a woman's roundtable -- sponsored by her magazine's Russian counterpart. Today, we will hear how Good Housekeeping is contributing to this national campaign to fight colon cancer.

One of the major forces behind this event today has been the National Colorectal Cancer Roundtable -- which is a newly formed coalition of professionals, consumer advocates, and voluntary organizations aimed at raising public awareness about the benefits of early detection. I want to thank Dr. Bernard Levin [LAVEEN] for his strong leadership as chair of that coalition.

I also want to welcome the many cancer survivors and their families who are with us today -- who are living proof that early detection saves lives; and the many doctors and public health advocates here this morning, who day in and day out, help us to lead longer, healthier lives. And welcome to our corporate partners here today, who have such a critical role to play in helping to spread the word about colon cancer.

It is fitting that we begin this program by hearing from someone who has committed her life to improving the health and welfare of America's families. HHS Secretary Donna Shalala, has been a key player in almost every social challenge facing this country today. Her national pastime is to break records -- not on the ball field -- but in the record books of our nation's health. Thanks to her tireless leadership -- we're making some important gains: infant mortality is at an all time low; kid's immunizations are at an all time high; more mothers are benefitting from early prenatal care; and teen births are dropping. So it is my pleasure to introduce Donna Shalala, Secretary of the Department of Health and Human Services.

[After Secretary Shalala, Dr. Levin (who introduce the PSA) and Ellen Levine speak, Katie Couric introduces the First Lady.]

Thank you, Katie, for those extremely difficult and powerful words. Nothing we can say here today can diminish the pain and loss you feel. But as you have just said so courageously -- what we can do is act -- by doing everything within our individual and collective powers to place colon cancer on the top of the nation's health agenda -- so that fewer families and communities will have to endure the pain and loss you and so many others have to face every day. And that's why we are here -- to help launch a national effort to increase public awareness around colon cancer -- and save lives.

This afternoon, we've heard how this deadly disease kills more than 50,000 Americans a year, devastating communities, and breaking the hearts of family and friends. But that's only half the message. Colon cancer is also a disease we have the power to control -- and beat. We know we can dramatically lower those deadly statistics -- by raising public awareness, expanding research, and promoting early detection. But we must recognize, as individuals and as a nation, the enormous task ahead of us.

According to a new survey by the Gallop Organization being released today, nearly 50% of Americans over 50 -- the age group considered most at risk for developing colon cancer -- have never been screened for the disease. The survey also reveals that while colon cancer occurs almost equally in men and women, women over 50 are less likely than men to undergo screening. And minorities are less likely to undergo screening and testing than their white counterparts. We must do better, so that everyone -- regardless of race, gender, or background -- gets the information and services they need to lead healthy lives.

This survey underscores the central message that I hope will go out from this gathering -- and reach every city and town and household in the nation: that we must do all we can to raise awareness about the benefits of early detection. Don't be embarrassed. Don't put it off. Don't make excuses. Just do it. It can save your life.

In our discussion today, we've used a lot of figures and statistics to illustrate the magnitude of the challenge before us. But as we all recognize, and as Katie Couric and others have expressed so personally, every cancer statistic represents a loved one: a mother or father, a husband or wife; a brother or sister, a friend or a neighbor. As many of you know, the President's mother died of breast cancer -- after a valiant fight. But there are also many survivors -- people who took the tests and whose cancer was detected early -- and whose lives were saved.

I want to mention just a few of the colon cancer survivors who are with us today -- who are living proof that getting tested can save your life. Joan Foster had a family history of colon cancer, and she sought screening. In 1983, a malignant polyp was discovered and removed. Since 1985, she's had periodic screenings, which have been normal. Kathy Johnson, a school teacher, learned about her cancer during a colonoscopy -- and has reached her five year survival period. Bob Williams discovered a cancerous polyp after a test. He's now retired, and drives cancer patients to their treatments, and volunteers at the local United Ostomy Association.

I want to thank all of the survivors here today and across the country. Your courage in reaching out to others at a very difficult time in your own lives has been an inspiration to us all. Yours are the stories that people listen to and learn from. As one survivor said: "We're not just survivors, but celebrators of life." And all of you deserve our heartfelt thanks and appreciation.

Today, it is my pleasure and honor to announce a series of new initiatives and partnerships which will help expand the number of colon cancer survivors across our nation, and ensure that more people like Joan and Bob and all the survivors here today can continue to lead productive, fulfilling, and generous lives.

At the federal level, I'm pleased to announce an important new \$10 million HHS grant -- from the National Cancer Institute to the Gastrointestinal Program Project in Seattle. The money will help scientists identify new ways of determining who is at risk -- and to test new strategies to reduce that risk. It will also help develop more sensitive and precise ways of screening colon cancer than those now available today. So thank you, Secretary Shalala, for your ongoing leadership on this issue.

Yet as much as the federal government is accomplishing in areas like research, there is a critical role for the private sector to play as well -- particularly in getting the word out to the general public. We've just previewed one of the tools of this new campaign -- the PSA that will help raise public awareness about colorectal cancer and the need to get tested. But we've got to get it out to the American people. That's why I'm so pleased that NBC will air it -- and that Good Housekeeping will run the print version in its January issue.

Today, I'm also delighted to announce a number of new partnerships with private industries that will not only help raise public awareness about colon cancer but also promote prevention and early detection screenings among their employees.

Among those initiatives: American Airlines will place the printed version of the PSA in its in-flight magazine -- reaching as many as 2 million Americans a year; Kellogg Company USA will print public service messages on its cereal packages; American Greetings will create a prescription insert about prevention and early detection -- and the National Association of Chain Drug Stores will distribute the insert through its pharmacies. Other companies -- including Bristol Myers Squibb, Zeneca Pharmaceuticals, Olympus America, Smithkline Diagnostics, General Motors, and Eli Lilly -- have also committed to raise awareness about colon cancer among their workers. These programs -- because they are aimed at people in their workplaces and communities -- will make a very real difference in the health and welfare not only of their employees, but of the general public. I applaud these efforts -- and hope that other companies will follow your example.

Spreading the word, and sharing information, is a key component of this national effort to reduce colon cancer deaths -- particularly when discussion of this cancer is still whispered about behind closed doors. So I'm pleased to announce that the American Digestive Health Foundation -- a member of the Roundtable -- is launching its internet chat room on colorectal cancer. It will give consumers, cancer patients, family members, survivors, and those at risk a new source of important information -- and a safe place to engage in real, live discussions about the issues they care about.

We've come together today to shine the spotlight on colon cancer -- because it's one of those cancers that no one wants to talk about -- and because there's so much we can do to diminish its deadly toll. But we cannot lose sight of the need to launch an offensive against all cancers -- which together strike down over 560,000 citizens a year. I want to take a moment to boost an important event coming up on September 25th and 26th, here in Washington, D.C. -- the largest single rally ever to focus national attention on the devastating problem of cancer in America. So I hope many of you -- and our listeners around the country -- can participate.

On behalf of my husband and the entire Clinton Administration, I want to thank each one of you for what you have already contributed to this national initiative to combat colon cancer. But real progress depends on the hard work we do in the months and years ahead, in our communities and workplaces and homes - - to educate people about colon cancer and how to prevent it.

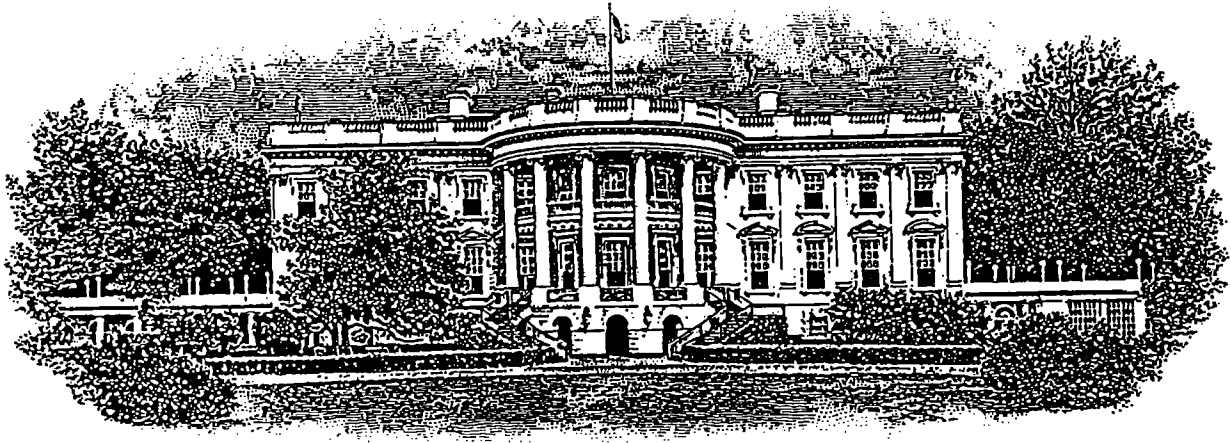
We've heard today that everyone over 50 should be screened. But we've also heard from Katie and others that we've lost the precious lives of too many at an earlier age. My simple advice to you today is to talk about screenings and prevention with your doctor, and find out what's appropriate for you. But as one survivor warns -- "Don't let fear rob you of your destiny."

I wish we could harness all of the energy and courage and commitment that so fills this room today -- and unleash it in communities across the country to fortify us for the tough fight ahead. We know we can prevail over this killer disease. And we owe it to our families -- to ourselves -- and to the memories of those we've lost -- to keep struggling until we succeed.

Thank you.

The White House

DOMESTIC POLICY COUNCIL



FAX COVER SHEET

To: Carol Beach

Phone: _____ Fax No: 301-957-0340

From: Heena

Phone: _____

Comments: Colon cancer stuff:



FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

DATE: 9-10
TO: Neva
FAX: 202 456-2878 PHONE: _____
FROM: Jeff Denny

OASPA/SPEECH DIVISION
Phone: 202-690-7470
Fax: 202-690-7318

TOTAL NUMBER OF PAGES TRANSMITTED: 3

COMMENTS:



U.S. Department of
Health & Human Services

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Senior Advisor for Communications

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*Here's the
final*
-JD

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But just as Mark McGwire won't start taking walks, we won't walk away from this fight. And that's why we're here today -- to strike out colorectal cancer. Although many Americans don't know it, colorectal cancer is one of our nation's biggest killers. It often strikes in the prime of life -- and hits men and women almost equally. And most important, although it tends to run in families, no one is immune. This is a seemingly bleak story.

But turn the page because behind it is a story of discovery, change and hope. Today, the death rate from colorectal cancer is dropping. We know that a high-fiber, low-fat diet cuts the risk of this terrible disease. And we've discovered a genetic marker that makes critical early detection easier. Research proves that a special test for colorectal cancer -- just once a year -- reduces the chance of death in people 50 to 80. The screenings are now covered by Medicare. And the examinations are getting easier as new diagnostic equipment makes screenings quicker and less painful.

But as a nation -- and as individuals -- we need to do more against colorectal cancer. We must keep stepping up to the plate. Because too many people are still suffering and dying from a cancer we can prevent, treat -- and even beat. We need a sustained effort -- and the tireless support -- of government, academic health centers, private research institutions and major corporations. We need Congress to pass the appropriations bills that include a multi-billion dollars in cancer research funding over the next five years. And most importantly, we need to get out the word about colorectal cancer.

That's our goal here today. Because knowledge is our best weapon. Prevention is our best strategy. And the best prevention is to eat smart. Know your family history. And get a regular screening after age 50. That's a message that the National Colorectal

Cancer Roundtable – with major help from the CDC – is bringing to homes across America.

Roundtables are like great baseball teams. Everyone is necessary, but there will always be a Mark McGwire – or a King Arthur – leading the charge. The head of the National Colorectal Cancer Roundtable has that kind of extraordinary leader of vision and courage. So I'm proud to introduce a knight in shining armor for every American fighting colorectal cancer, Dr. Bernard Levin.



FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

*These have
substantially
changed*

DATE: 9/6/98

TO: Nelra

FAX: 202-456-2878

PHONE: _____

FROM: H. Lavine

Phone: (202)

Fax: (202)

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The Sec. has signed
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Howard*



U.S. Dept. of Health and Human Services
Office of the Secretary

HOWARD D. LAVINE
Speechwriter

Room 629E, H. H. Humphrey Bldg.
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American
Digestive
Health
Foundation



Facsimile Cover Sheet

ADHF, 7910 Woodmont Ave., Suite 700, Bethesda, MD 20814

To: Neera Tanden

From: Carole Anikis

Company: American Digestive Health Foundation

Phone: (301)941-2626

Fax: (301)654-5920

Email: canikis@gastro.org

Date: September 9, 1998

**Pages including 5
this cover page:**

Neera:

Here are Bernard's remarks, incorporating your changes, and the changes to the speaking order. He hasn't seen them yet, but we'll tell him he can't make substantial changes!

**Remarks by Dr. Bernard Levin
White House Event
September 10, 1998**

Thank you, Secretary Shalala. Good afternoon Mrs. Clinton. Good afternoon ladies and gentlemen. I am Dr. Bernard Levin, vice president for cancer prevention at the University of Texas M.D. Anderson Cancer Center, and chair of the National Colorectal Cancer Roundtable. Recently founded by the American Cancer Society and the Centers for Disease Control and Prevention, the Roundtable is a coalition of 25 medical professional, consumer advocacy and voluntary organizations, many of which are represented here this afternoon. Our mission is to reduce the suffering and mortality from this disease by achieving screening rates for colorectal cancer that are equivalent to those for other cancers. Currently, for example, four out of five people are screened for breast and cervical cancer. Colorectal cancer screening rates are nowhere near that and we need to be.

We've all heard the old saying, "an ounce of prevention is worth a pound of cure." As a practicing physician who specializes in colon cancer, I

Levin/2

can tell you that nothing is more true of this disease. From where I sit, the real tragedy of 50,000 deaths a year from colorectal cancer is that so many of them can be prevented. I have sat by the bedsides of too many patients with this cancer, and have sympathized with too many family members who have lost loved ones to this disease, simply because they were not screened.

Colorectal cancer is preventable. Moreover, colorectal cancer is curable when detected early. In fact, if we instituted widespread screening for the disease as a national priority, we could reduce the death rate by at least 50 percent. There is no other disease about which we can make this claim.

Sadly, too many people are not getting this message, even from their physicians. The number of doctors who fail to recommend screening for their patients over age 50 is alarming. Physicians must make screening for colorectal cancer a routine part of their practices. General practitioners,

Levin/3

family doctors, internists, gynecologists – all must inform their patients over 50 of the benefits of screening and urge them to get tested. In fact, better education of physicians is a primary goal of the National Colorectal Cancer Roundtable. Medicare now reimburses the cost of screening for those over age 65 – a wise decision by the Administration and Congress.

In addition to screening, lifestyle choices can help to prevent colorectal cancer. Eating plenty of vegetables and high fiber foods, as well as exercising regularly, can lower your risk. And know your family history. People with a close relative who has had colorectal cancer are at higher risk of developing the disease themselves, and should start screening earlier.

In keeping with our efforts to get these messages out, I am pleased now to unveil a new public service announcement campaign, starring the First Lady. The National Colorectal Cancer Roundtable is grateful that Mrs. Clinton is taking this leadership role in the fight against colorectal cancer,

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and we are honored that she serves as our Honorary Chair. We are also very excited that NBC network has agreed to air the public service announcement you are now about to see. Please look to the monitors on either side of the room.

[play PSA]

I am pleased now to introduce the Editor-in-Chief of *Good Housekeeping* magazine, which will publish Mrs. Clinton's print public service announcement in its January issue. Ladies and gentlemen, Ellen Levine.

Good Housekeeping

959 EIGHTH AVENUE, NEW YORK, NY 10019 * 212-649-2200 * FAX 212-265-3307

September 4, 1998

TO: Neera Tanden

FROM: Debbie Pike

RE: Ellen Levine's remarks for colon cancer event

Today is an important day; it marks the beginning of a new public health campaign that has the power to save thousands of lives. Good Housekeeping believes we must start talking about colon cancer. Women have always used their personal experiences to raise public awareness of disease and save the lives of their families and friends. It's really easy to forget that thirty years ago, no one talked about breast cancer. It was embarrassing. It was the C-word. But when former First Lady Betty Ford spoke out about her breast cancer diagnosis, other well-known people followed. Then, slowly, women began to get mammograms, though not enough doctors were encouraging it--despite the fact that science was beginning to show that routine testing could save lives. Just ten years ago, only 27 percent of women age 50 and over were being tested. Today, that number has more than doubled--at least 60 percent of women age 50 and over are getting screened. And there's been a substantial decline in deaths from breast cancer--the largest drop since 1950. How did this happen? In no small way, thanks to women's voices, the famous and the not-so-famous, talking out loud about taking care of themselves and raising our awareness of breast cancer.



Now it's time for women to speak out about colon cancer. I became too aware of the disease. Many dear friends have been diagnosed with it. This year, colon cancer will claim the lives of more women than men--primarily because women aren't being screened. There are many reasons for this: Women wrongly believe colon cancer is a man's disease; our doctors don't insist we be tested; or we're too afraid or embarrassed. Even I, who should know better, postponed screening until January of this year, just because I thought it was going to be unpleasant. That's a tragedy, because screening has been proven to save lives.

We at Good Housekeeping want to spread the word, so we've devoted a section of our October Issue to what women can do to protect themselves. Experts told us over and over again that early detection is key. At least one woman in the audience today is living proof of that message. Last March, Elizabeth Ely, a 55-year-old interior decorator in New York City, decided to have a colonoscopy, a test that allows a doctor to check the entire colon for abnormalities. Her physician had urged her to get screened because of her age. After the test, she was shocked to learn she had a malignant rectal tumor. Fortunately, it was an early-stage cancer, and surgery cured her. But her experience was a real wake-up call.

In our efforts to raise awareness of colon cancer, we turned to Katie Couric, a very brave woman and brilliant newscaster. All over America, people tune in to the Today Show and recognize Katie as a friend, daughter, sister or mother. And all over America, we are

aware that her leadership on this issue has come the hard way.

Women like Katie take their responsibilities not just to their families but to their public with a seriousness. She knows a lot more ~~about this disease~~ than many doctors, and she's convinced that our ~~ability to talk openly~~ about colon cancer will simply save lives. *stat*

Now I'd like to introduce a woman I consider a good friend and one of the great voices of our time: Katie Couric, anchor of the Today Show.

30 Rockefeller Plaza
New York, NY 10112
212 664-4444

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Company, Inc.



Christy
x 65709

TODAY SHOW

FAX COVER SHEET

TO: Neera Tanden 202-456-7805
Toby 202-456-2878

FROM: Joy Richter

RE: Katie Couric Remarks
+ TODAY SHOW SERIES OUTLINE

#PAGES INCLUDING COVER 5

jrlichter

Wed Sep 9 14:40 page 1

SLUG	SHOW	WRITER	MODIFIED jrlichter	TIMING
WHITE HOUSE REMARKS		kcouric	Wed Sep 9 14:40 1998 HOLD	3:58 12
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THANK YOU ELLEN.

I WISH I COULD SAY I'M HAPPY TO BE HERE ON THIS OCCASSION, AS MANY OF YOU KNOW THAT COULDN'T BE FURTHER FROM THE TRUTH. BUT I AM SO GRATEFUL TO MRS. CLINTON FOR HER INTEREST AND COMMITMENT, TO ELLEN LEVINE AND THE STAFF OF GOOD HOUSEKEEPING FOR THEIR INCREDIBLY THOROUGH COVERAGE IN THEIR UPCOMING OCT. ISSUE AND THE TODAY SHOW PRODUCERS AND STAFF FOR WHAT I HOPE WILL BE A LIFE-SAVING SERIES ON COLON CANCER THAT WILL AIR NEXT WEEK.

FOR THOSE OF YOU WHO HAVE HAD FIRST-HAND EXPERIENCE WITH COLON CANCER - FOR THOSE WHO HAVE BEEN TO HELL AND BACK, OR HAVE LOVED ONES WHO WERE TRAGICALLY UNABLE TO MAKE THE RETURN TRIP...YOU KNOW ALL TOO WELL AND TOO MUCH ABOUT THIS DEVASTATING DISEASE.

OUR EYES SEEM TO GLAZE OVER WHEN WE HEAR CANCER STATISTICS. BUT SOMETHING STRUCK ME RECENTLY. I WAS HEARTBROKEN AS I'M SURE YOU WERE WHEN YOU HEARD THE NEWS ABOUT THE PASSENGERS ABOARD SWISS AIR FLIGHT 111. 229 LIVES LOST. BUT AN EQUALLY SENSELESS TRAGEDY IS THAT IT WOULD TAKE 247 OF THOSE PLANES FULL OF PEOPLE TO MAKE UP THE MORE THAN 56,000 WHO DIE EVERY YEAR OF COLON CANCER. COLON CANCER KILLS MORE PEOPLE THAN BREAST AND PROSTATE CANCER COMBINED. EVERY LIFE IS PRECIOUS, EVERY LOSS DEVASTATING. BUT CLEARLY, IT'S TIME WE PUT COLON CANCER ON THE FRONT BURNER. WE'VE GOT TO INCREASE AWARENESS--EDUCATE THE PUBLIC...ENCOURAGE, NO---FORCE PEOPLE TO TAKE ADVANTAGE OF THE DIAGNOSTIC TOOLS THAT EXIST, COERCE INSURANCE COMPANIES TO PAY FOR COLON CANCER SCREENING AND NOT JUST FOR PEOPLE WHO HAVE SYMPTOMS OR A FAMILY HISTORY OF THE DISEASE. ANYONE WHO WANTS TO PREVENT COLON CANCER...AND YOU KNOW OF COURSE, IF IT'S CAUGHT EARLY, THERE'S A 90 PERCENT CURE RATE...SHOULD BE ABLE TO. IT WILL SAVE THE HEALTH CARE SYSTEM UNTOLD MILLIONS IN THE LONG RUN.

I SUFFERED A VERY PERSONAL LOSS, ONE THAT I DEAL WITH EVERY MINUTE OF EVERY DAY. JAY WAS A GIFTED, HIGHLY INTELLIGENT MAN OF COMPASSION AND INTEGRITY...WITH EVERYTHING TO LIVE FOR, INCLUDING TWO ADORED AND ADORING

DRAFT**DRAFT**

**Private Industry Partnerships
Promote Awareness of Colorectal Cancer Prevention and Detection**

The National Colorectal Cancer Roundtable, a coalition of medical professional, consumer advocacy and voluntary organizations, has formed partnerships with members of private industry to raise awareness of the importance of colorectal cancer prevention and early detection. These national companies have committed to activities that will educate thousands of Americans over the age of 50 about the importance of getting screened for colorectal cancer, the nation's second leading cancer killer.

American Airlines

mentio
American Airlines' in-house medical staff will provide free colorectal cancer screening cards to more than 200,000 employees, spouses and retirees. In addition, American Airlines will publish First Lady Hillary Rodham Clinton's public service announcement on colon cancer testing in its in-flight magazine, *American Way*, reaching approximately two million air travelers in the U.S. and around the world.

Kellogg Company

mentio
Kellogg will promote colorectal cancer prevention and early detection messages to a variety of audiences, including: its thousands of employees and retirees through its publication, *The Kellogg News*; to company consumers via five million packages of Kellogg's All Bran and Bran Buds; to 5,000 hospital health care sites; to 5,000 health care professionals; and to 500 retailers. In addition, Kellogg Company will provide in-store consumer education messages in 12,000 stores, as well as information on the Internet generating approximately five million "hits" per month.

Olympus America Inc.

mentio
Olympus America will sponsor a "Colorectal Cancer Education - What Everyone Needs to Know" program which will be open to employees, family members and the general public. The program will be held at Olympus America headquarters in Melville, NY or at a local medical university, and will be repeated at Olympus' repair and distribution facility in San Jose, CA. A panel of leading experts will speak about the problem of colorectal cancer, as well as solutions (preventive measure, nutrition, screening). The program will be announced through a direct mail piece and internal *Olympus Bulletin*.

The program will be videotaped and shown at the five Olympus Service Center branches in Atlanta, Cleveland, Chicago, Dallas and Long Beach. In addition, Olympus will initiate a direct mailing to the administrators of retirement communities across the country, offering copies of the videotaped program at no cost.

Zeneca Pharmaceuticals

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In the fall of 1998, Zeneca will offer to all employees over the age of 40 a new educational session on nutrition and its role in colorectal cancer. In early 1999, a new session on the importance of screening women for colorectal cancer will be offered to employees. In addition, in 1999, a new worksite guide for detection/screening for colorectal cancer will be issued for customer use.

Beckman Coulter, Inc./SmithKline Diagnostics, Inc.

1158
Beckman Coulter/SKD will publish First Lady Hillary Rodham Clinton's public service announcement on colorectal cancer testing through the company intranet and in-house publication, *Beckman Coulter Life*, reaching more than 10,000 employees worldwide. SKD-trained representatives and in-house support staff of 50 will promote the message about screening for colorectal cancer by making themselves available to National Colorectal Cancer Roundtable participants and partners. ~~SKD will send a written message to the Roundtable partners offering its Basic Training™ Patient Education Program.~~

Bristol-Myers Squibb Oncology

1159
Bristol-Myers Squibb Oncology has provided an initial \$100,000 grant for the Better Health Foundation to develop a colorectal cancer workplace awareness program that companies nationwide can adopt at no cost. Bristol-Myers Squibb Oncology will initiate the program at all of its work sites.

General Motors Corporation (

It appears that General Motors will do the following, but I'm not sure:

1158
1-5
General Motors will publish an article (?) in its newsletter, [insert name], distributed to ~~all~~ employees ^{importance of colorectal cancer prevention} ^{feel in God} ~~and retirees~~ ^{families} focusing on colorectal cancer prevention and early detection. The article will encourage employees to access the audio tapes General Motors has in its Audio Health Library on colorectal cancer risk factors, early detection guidelines, signs and symptoms, and treatment. The article will remind enrollees in GM's wellness program that they can discuss questions or symptoms with registered nurses available through a toll-free number. The article will also contain information on how wellness program enrollees can access web site information on the prevention and early detection of colorectal cancer, and encourage them to read their program self-care book.

Eli Lilly and Company

Eli Lilly launched a colon cancer prevention and screening program in 1996, available to health plan members over the age of 40. Eli Lilly will recommit and increase efforts to encourage employee participation in the program through employee communications using both publications and broadcast services.

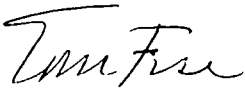
Ms. Wooley
Ms. Tanden
Page 2

3. background details on our plans for a spokesperson and public service announcement relationship with baseball star Eric Davis, whose battle with colorectal cancer mesmerized countless sports fans over the past year;

4. and a collection of print educational materials we have been disseminating.

I look forward to joining forces with the others who attended our meeting, and returning to visit with you again next month. If I can fill in any details in the meantime, please let me know.

Very Truly Yours,

A handwritten signature in cursive script, appearing to read "Tom Fise".

Thomas F. Fise
Executive Director

enclosures

cc: Sarkis J. Chobanian, M.D., FACP, ACG President
Martha M. Kendrick, Esquire, Patton Boggs, ACG Counsel

**PROPOSED AMBULATORY SURGICAL CENTER PAYMENT STATUS
BY HCPCS CODE**

CPT/ HCPCS	Description	Current Payment Rate	Proposed Payment Rate	% Increase/ Reduction
43234	Upper GI endoscopy, exam	\$314	\$327	+4%
43235	Upper GI endoscopy, diagnosis	\$314	\$327	+4%
43239	Upper GI endoscopy, biopsy	\$422	\$327	-23%
43260	Endoscopy, bile duct/pancreas	\$422	\$473	+12%
45330	Sigmoidoscopy, diagnosis	--	\$175	--
45378	Diagnostic colonoscopy	\$422	\$354	-16%
45385	Colonoscopy, lesion removal	\$422	\$405	-4%

Based on Federal Register, June 12, 1998.

II. Background on Differential Reimbursement for Part B Physician Fees for Hospital Outpatient-Based vs. Office-Based Services & ACG's Key Objectives

ACG is very concerned that HCFA took the initial step toward differentiating physician fees for office-based procedures from those performed on an outpatient basis at either an ambulatory surgery center ("ASC") or in a hospital outpatient facility when the agency published separate facility/non-facility fee reimbursement rates in its 1998 Medicare physician fee schedule. While the differences are small this year, if left unattended, more widespread reduction in the RBRVS professional fee for services done in the ACS or hospital will ensue.

ACG believes that the Final 1998 Medicare Physician Fee Schedule Rule, published by HCFA in October, 1997 **irrationally establishes different practice expense relative value units (RVUs) and therefore, differing reimbursements for certain endoscopic procedures depending on whether such procedures are provided in a facility or non-facility setting.** HCFA has now published a new practice expense rule in which it reiterates this ill-conceived approach. HCFA has relied upon the BBA's "down-payment" provision (and its reference to the original June, 1997 practice expense proposal) to justify the bifurcated approach. We think the overall intent of BBA was to critique the June, 1997 rule, not to endorse it. We definitely do not think Congress intended a complete restructuring of the Medicare Fee Schedule on such an untested, bifurcated framework.

Congress' decision to delay implementation of resource-based practice expense RVUs reflects the concern that HCFA could not generate reliable practice expense data prior to the original January 1, 1998 implementation deadline. ACG believes that HCFA should have used the additional one-year period granted by Congress to further develop practice expense data so that practice expense RVUs, once implemented, will reflect accurate practice expenses for all providers. No bifurcation of the fee schedule into facility and non-facility categories should legitimately be implemented. Doing so would be detrimental to both patients and physicians.

The Differentiation of Non-Facility vs. Facility Under Both Practice Expense RVUs and Total RVUs is Inappropriate

HCFA inappropriately and prematurely re-structured the Medicare physician fee schedule in establishing differing levels of physician Part B reimbursement depending upon where the procedure was performed. From the beginning of the Medicare physician fee schedule through the 1997 fee schedule (published in the *Federal Register* on November 22, 1996), with very rare exceptions, HCFA has observed a policy of a single fee for each CPT code, regardless of the site of service.

On June 18, 1997, HCFA published in the *Federal Register* its proposal to establish a new method for computing practice expenses. As part of the proposal first articulated in this publication for practice expenses, HCFA added separate computations for practice expenses for in-office and out-of-office services, increasing the number of columns for each CPT code from 4 (in the November 22, 1996 rulemaking) to 8 (in the June 18, 1997 practice expenses proposal). For the first time, this bifurcation approach resulted in two distinct composite RVUs per code--one labeled "Total In Office," and the second labeled, "Total Out-of-Office."

We believe this is inappropriate to carry this bifurcation forward in light of the absence of any explicit legislative directive to fundamentally change the Medicare physician fee schedule, and in light of the explicit Congressional decision to delay implementation of any new methodology for practice expenses until January 1, 1999.

The future Medicare physician fee schedule should be exactly the same as for the 1997 Medicare physician fee schedule, *i.e.*, a single value for the practice expense RVUs for each code, and a single total RVUs for each code. The differentiation of non-facility vs. facility under both practice expense RVUs and total RVUs is inappropriate. HCFA's decision to impose the facility/non-facility differentiation now undercuts the validity and fairness of the entire fee schedule.

The incongruity of HCFA's process and the lack of validity is apparent when we examine what the agency has promulgated. Some codes remain unchanged from 1997--with identical facility and non-facility values. Codes that have smaller reimbursement levels have differentials/reductions between facility/non-facility payments that are twice as large as for other services with double the level of reimbursement.

As Published, this Bifurcated Approach is Clearly Inequitable...

Obviously HCFA's approach is not sufficiently coherent to form the basis for reimbursement under the Medicare program. Consistent with all other years, a single office/ASC/ outpatient physician professional fee without regard to site-of-service is needed, and **should have been set at the higher of the two published amounts (excluding any reduction arising from the anticipatory bifurcation.)**

Legislative Technical Correction Needed to Redress this Unfair Scheme...It Will Almost Certainly Be Necessary For Congress to Intervene to Establish That It Does Not Favor A Complete Restructuring Of the Medicare Fee Schedule in The Untested, Incentive-Laden, Bifurcated Framework

The fees as they should have been published are provided in Table 1 below. A technical correction should be added to any 1998 Budget Reconciliation legislation **instructing HCFA to adopt the consolidated fee approach for those and other bifurcated services, and directing HCFA to make adjustments to fees retroactive to January 1, 1998.** The corrected unified fees should be utilized in place of the bifurcated fees for purposes of all future adjustments, as if those had originally been published as the 1998 Medicare fees.

Congress must ensure that these key points are incorporated into any comprehensive legislation or voluntary initiatives dealing with patient rights.

CPT/Description	Single Value which should be Instated - Total RVUs	"Differential for Facility Site" which should be Excised - Total RVUs
43200/ Esophagus endoscopy	3.89	3.60
43202/Esophagus endoscopy, biopsy	4.61	4.28
43234/ Upper GI endoscopy, exam	4.88	4.52
43235/Upper GI endoscopy, diagnosis	5.75	5.31
43239/Upper GI endoscopy, biopsy	6.46	5.98
44385/Endoscopy of bowel pouch	4.49	4.16
44388/Colon endoscopy	6.93	6.42
44389/Colonoscopy w/ biopsy	7.58	7.02
44391/Colonoscopy for bleeding	10.11	9.60
44392/ Colonoscopy & polypectomy	9.68	8.72
44393/Colonoscopy, lesion removal	10.95	10.86
44394/Colonoscopy w/ snare	10.29	10.00
45330/Sigmoidoscopy diagnostic	2.31	2.14
45331/Sigmoidoscopy and biopsy	3.02	2.80
45333/ Sigmoidoscopy & polypectomy	4.46	4.38
45378/Diagnostic colonoscopy	8.22	8.16
45378/53/Diagnostic colonoscopy	2.31	2.14
45379/Colonoscopy	10.50	10.36
45380/Colonoscopy and biopsy	9.20	8.82
45385/Colonoscopy lesion removal	12.54	11.73

GIVING THE NEW MEDICARE COLORECTAL CANCER SCREENING BENEFIT A CHANCE

Colorectal Cancer Screening Saves Lives...But Only If You Get Screened

Enactment of the new Medicare colorectal cancer screening benefit provides a powerful weapon in our arsenal in the fight against colorectal cancer. We have the wherewithal to **reduce deaths dramatically from America's #2 cancer killer through early detection**. But like mammography, the lifesaving potential of screening depends upon assuring that as many Americans as possible take advantage of this benefit.

We all know that colorectal cancer screening can save lives and ultimately, when widely implemented, will save money for the government and other payors as well. But we need help to **encourage, rather than discourage utilization of the new Medicare benefit** enacted in the Balanced Budget Act of 1997. We commend Congress and the Administration for making this lifesaving screening benefit available to Medicare beneficiaries. Now we must ensure that **access to screening is not limited by government action which serves to discourage or undercut utilization of the new benefit**.

We Recognize that Patient Resistance to Colorectal Cancer Screening is Strong...America's GI Specialists Have Assumed on the Challenge of Educating Patients and Physicians about the New Medicare Benefit and the Lifesaving Potential of Early Detection and Prevention

The Barriers to Screening are Already High; Don't Make Them Higher by Creating Economic Disincentives...Slashing Medicare Reimbursement and Denying the Facility Fee for High Risk Screening Tests at Ambulatory Surgery Centers Create Even Greater Impediments

Improved, active physician support for the new screening benefit is essential if we are to successfully persuade patients to put aside anxieties and receive screening. We simply **cannot afford to create additional impediments to screening in the form of economic disincentives--we cannot continue HCFA's deep, ongoing downward spiral of reimbursement** levels for the basic colorectal cancer screening tests mandated in the Balanced Budget Act, or by denying the facility fee portion of claims for high risk screening at ASCs.

The Bureaucratic Impediments...

- ▶ Currently, Medicare is not paying the facility fee for screening colonoscopies at ambulatory surgery centers, **simply because HCFA still has not promulgated the necessary "final rule" in the *Federal Register*** to add the new GO107 code to the ASC list. No alternative payment mechanism exists for these preventive services if delivered at ASCs.
- ▶ Reimbursement for flexible sigmoidoscopies has dropped to the point where **primary care physicians are discouraged from providing screening for average risk Medicare patients**. Proposals for deep cuts in reimbursement for diagnostic colonoscopies threaten to create a similar impediment for screening high risk patients.
- ▶ As demonstrated in the Table below, reimbursement for colorectal cancer screening tests **plummeted 40% from 1987 to 1992 and lost growth to inflation, increasing just 4% from 1992 to 1997**. Last year HCFA announced further plans to cut the reimbursement level for a diagnostic colonoscopy that is performed in a hospital outpatient department or an ambulatory surgery center by 50%, and a 39% decrease in the Medicare flexible sigmoidoscopy fee.
- ▶ Feedback received from primary care physicians in some communities indicates that with Medicare reimbursement of **only \$75 to cover all costs for professional fees, support staff, and supplies for a flexible sigmoidoscopy**, physicians cannot economically meet a demand -- much less instill compliance -- for this lifesaving screening test in the average risk patient. A similar reaction could prevail among gastroenterologists, if they find themselves performing diagnostic colonoscopies, including the risks related to conscious sedation, with **HCFA's proposed professional fee of \$138**.

The Challenges of Awareness and Compliance Among Patients AND Physicians...

Undeniably there is a **major impediment in patient resistance to colorectal cancer screening**--these are not tests to which anyone truly looks forward. The College launched a major national public awareness campaign to guarantee that both primary care physicians and patients are familiar with the new benefit, and to underscore for patients the importance of regular screening.

To measure the impact and effectiveness of expanded screening under Medicare, the American College of Gastroenterology plans to involve its 7,000 members to conduct a broad-based national registry later this year to try to **quantify in some way the impact of the new benefit in cancers detected and lives saved**.

Patient education is essential, and health care providers are the key to success. Recent health literature has numerous indicators of physicians being lax in not aggressively educating patients and recommending screening.

- ▶ the American Public Health Association reported that physicians are both unlikely to be screened for colorectal cancer themselves and that the majority do not recommend such screening to their patients.
- ▶ a study presented at the College's recent Annual Scientific Meeting reported that, in eligible patients seen by primary care or internal medicine residents at a major university medical center, approximately two-thirds had received mammography and Pap smears, a little over 50% had received cholesterol testing, but only 25% had received the fecal occult blood test, and only 16% received the screening flexible sigmoidoscopy. Ironically, these residents perceived that they were ordering these colorectal cancer screening tests for 75% of their eligible patients.

ACTION NEEDED:

HCFA's Proposed Reimbursement Cuts

Action by HCFA -- or inaction -- **could emasculate the colorectal cancer screening benefit by creating economic disincentives**. To guarantee the broadest possible availability and acceptance of the new benefit, ACG supports **restoration of fees for basic colorectal cancer screening tests and follow-up visits to the same level as when the RBRVS fee schedule was first introduced in 1992; that 1992 level should serve as a floor for the next five years**.

ASC Facility Fees for High Risk Screenings

One hallmark of the new Medicare colorectal cancer screening benefit is screening colonoscopy for those at highest risk for this devastating disease. Currently, HCFA's failure to provide timely authorization to reimburse facility fees at Ambulatory Surgery Centers for screening colonoscopies contradicts Congressional intent that total reimbursement for **screening** colonoscopy match those for the **diagnostic** colonoscopy. ACG urges Congress to mandate that HCFA immediately restore the reimbursement parity between the codes for colorectal cancer screening tests and the other Medicare counterpart codes (*e.g.*, authorizing payment for ASC facility fees), effective for all services performed since implementation of the benefit on January 1, 1998.

Table 1. *Trends in Medicare Reimbursement for Colorectal Cancer Screening Tests*

CPT Code	Procedure	Nat'l Avg 1989	1992 Fee (RVU)	Reduction 89 to 92	1997 Fee (RVU)	Change 92 to 97	Current 98 RVU In-Hosp. or ASC	Current 98 Fee In-Hosp. or ASC	HCFA Prop. RVU In-Hosp. or ASC 6/5/98	HCFA Prop. Fee In-Hosp. or ASC 6/5/98
45330	Sigmoid.	\$106.00	\$78.12 (2.52)	-\$27.88 (-26%)	\$78.18 (2.31)	+\$0.06 (0%)	2.14	\$78.51	1.46	\$53.56 (-33%)
45378	Diagn. Colnscopy	\$452.00	\$262.89 (8.48)	-\$189.11 (-42%)	\$278.21 (8.22)	+\$15.32 (5.8%)	8.16	\$288.10	6.06	\$208.17 (-28%)
45380	Colnscopy/ biopsy	\$503.00	\$294.20 (9.49)	-\$208.80 (-42%)	\$311.38 (9.20)	+\$17.18 (5.8%)	8.82	\$323.58	6.15	\$225.62 (-30%)
45385	Colnscopy/ polyp.	\$704.00	\$420.04 (12.46)	-\$283.96 (-40%)	\$424.42 (12.54)	+\$4.38 (1%)	11.73	\$414.17	8.11	\$277.71 (-33%)

HCFA's Fee Schedule Payment

SERVICE	1987	1997	What You Are Paid in 1998		What You Would Be Paid in 2002 (With new Practice Expense Changes Per HCFA's June 1998 Proposal)	
	Fee	Fee	<u>Outpatient</u>	<u>Office</u>	<u>Outpatient (RVU)</u>	<u>Office (RVU)</u>
EGD (43234)	\$344.22	\$165.17	\$165.82 (4.52)	\$179.03 (4.88)	\$116.29 (3.17)	\$170.96 (4.66)
EGD (43235)		\$194.61	\$194.80 (5.31)	\$210.95 (5.75)	\$134.27 (3.66)	\$237.73 (6.48)
EDG w/biopsy (43239)		\$218.64	\$211.20 (5.98)	\$228.81 (6.46)	\$140.58 (4.11)	\$241.66 (6.90)
ERCP (43260)	\$532.52	\$417.31	\$452.35 (12.33)	-----	\$314.04 (8.56)	-----
Flex. Sig. (45330)	\$148.46	\$ 78.18	\$ 78.51 (2.14)	\$ 84.74 (2.31)	\$ 53.56 (1.46)	\$165.09 (4.50)
Colonoscopy (45378)	\$509.23	\$267.82	\$288.10 (8.16)	\$290.30 (8.22)	\$208.17 (6.06)	\$292.34 (8.38)
Colonoscopy with lesion removal (45385)		\$424.42	\$414.17 (11.73)	\$443.89 (12.54)	\$277.71 (8.11)	\$414.17 (10.82)

HCFA-Generated Table

Table 9. Comparison of Resource-Based Practice Expense Relative Value Units Impact on Total Allowed Charges by Specialty with the June 97 NPRM Net of the Down Payment (percent change)

Specialty	June 97 NPRM	Impact of Practice Expense	June 97 NPRM	Modified June 97	PE/HR
M.D./D.O. Physicians:					
Anesthesiology	4.0	0.2	3.8	9	2
Cardiac Surgery	-32.0	-2.9	-30.0	-37	-14
Cardiology	-17.0	-1.1	-16.1	-21	-13
Clinics	-3.0	0.1	-3.1	-5	-3
Dermatology	18.0	0.6	17.2	36	27
Emergency Medicine	-2.0	-0.1	-1.9	-6	-13
Family Practice	12.0	2.0	9.8	7	6
Gastroenterology	-20.0	-0.9	-19.3	-24	-14
General Practice	9.0	1.5	7.4	5	3
General Surgery	-9.0	-0.2	-8.8	-16	-6
Hematology/Oncology	11.0	1.2	9.7	15	2
Internal Medicine	3.0	1.2	1.8	-2	1
Nephrology	-13.0	-0.7	-12.4	-17	-5
Neurology	-3.0	0.5	-3.4	-7	0
Neurosurgery	-21.0	-1.6	-19.7	-27	-10
Obstetrics/Gynecology	4.0	1.5	2.5	0	5
Ophthalmology	-11.0	-3.3	-8.0	-3	11
Orthopedic Surgery	-11.0	-0.9	-10.1	-14	-1
Other Physician*	4.0	0.2	3.8	2	0
Otolaryngology	7.0	0.5	6.5	8	6
Pathology	1.0	-0.6	1.6	5	-10
Plastic Surgery	-3.0	-0.3	-2.7	-9	5
Psychiatry	3.0	-0.1	3.1	19	4
Pulmonary	-8.0	0.1	-8.1	-10	-3
Radiation Oncology	10.0	-0.4	10.4	15	-13
Radiology	-9.0	-0.3	-8.7	-13	-13
Rheumatology	15.0	2.0	12.8	11	15
Thoracic Surgery	-28.0	-2.3	-26.3	-33	-13
Urology	1.0	0.1	0.9	2	7
Vascular Surgery	-17.0	0.3	-17.2	-23	-12
Others:					
Chiropractic	14.0	-0.3	14.3	-2	-2
Nonphysician Practitioner	4.0	-0.7	4.8	-1	-1
Optometry	15.0	0.7	14.2	36	36
Podiatry	24.0	0.6	23.3	5	5
Suppliers	14.0	-0.8	14.9	-18	-18

*Other physician includes allergy/immunology, oral surgery, physical medicine and rehabilitation, pediatrics, critical care, and hematology.

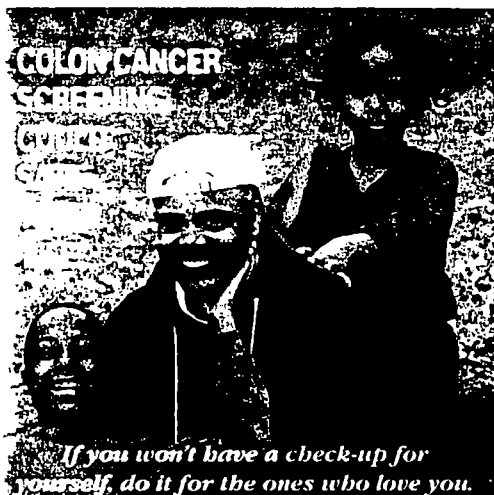
HCFA-Generated Table

Table 1. Mean practice expenses per hour spent in patient care activities, hours and expenses adjusted for practice size (in dollars)

SPECIALTY	# OF CASES	NON-PHYS PAYROLL PER HOUR	CLERICAL PAYROLL PER HOUR*	OFFICE EXPENSE PER HOUR	SUPPLIES EXPENSE PER HOUR	EQUIPMENT EXPENSE PER HOUR	OTHER EXPENSE PER HOUR	TOTAL EXPENSE PER HOUR**
ALL PHYSICIANS	3910	27.0	15.0	19.1	7.2	3.2	11.0	67.5
GENERAL/FAMILY PRACTICE	409	30.2	15.1	18.2	8.1	3.6	8.6	68.6
GENERAL INTERNAL MEDICINE	430	22.4	13.3	17.0	6.4	2.1	6.2	54.2
CARDIOVASCULAR DISEASE	94	30.2	14.9	19.9	5.8	6.4	20.7	82.9
GASTROENTEROLOGY	84	23.2	15.4	17.9	2.7	1.8	11.0	56.6
ALLERGY/IMMUNOLOGY	31	25.2	21.5	33.3	11.1	3.3	16.4	136.6
PULMONARY DISEASE	49	29.0	12.2	15.0	1.9	1.6	6.4	45.8

Table 11. Total Payment For Selected Procedures

Code	Mod	Description	Current Non-facility	Resource Based Non- facility	Non- facility percent change	Current Facility	Resource Based Facility
33533		CABG, arterial, single	NA	NA	NA	\$2,107.91	\$1,764.20
35301		Rechanneling of artery	NA	NA	NA	\$1,262.70	\$1,069.02
43239		Upper GI endoscopy, biopsy	\$228.81	\$241.86	6%	\$211.20	\$140.58
45378		Diagnostic colonoscopy	\$290.30	\$282.34	1%	\$288.10	\$208.17
45385		Colonoscopy, lesion removal	\$443.89	\$375.88	-15%	\$414.17	\$277.71
66821		After cataract laser surgery	\$187.65	\$192.66	3%	\$187.65	\$184.24
66984		Remove cataract insert lens	NA	NA	NA	\$795.26	\$677.97



AMERICA'S #2
CANCER KILLER...

colon cancer

...YOU CAN
PREVENT IT

A Proposal for Eric Davis Baltimore Orioles

To Serve as a National Spokesperson
for the Colon Cancer Awareness Program
of the American College of Gastroenterology

A *modest* investment
of your time could
make a **BIG**
difference in the fight
against colon cancer

Join us by lending your
name to a major, *national*
effort to raise awareness
among all *Americans*



AMERICAN COLLEGE OF GASTROENTEROLOGY

Digestive Disease Specialists Committed to Quality in Patient Care

4900 B South 31st Street Arlington VA 22206 Phone: 703-820-7400 Fax: 703-931-4520 Website: www.acg.gi.org

A PROPOSAL FOR
ERIC DAVIS
TO SERVE AS NATIONAL SPOKESPERSON FOR
COLORECTAL CANCER SCREENING PUBLIC EDUCATION
PROGRAM
OF THE AMERICAN COLLEGE OF GASTROENTEROLOGY

The life challenges which you have encountered, and the bravery you and your family demonstrated in the face of adversity have had a profound effect on millions of Americans, and have done much to advance general awareness about America's #2 cancer killer, colorectal cancer.

With your experience you are keenly aware that colorectal cancer deaths frequently can be avoided with early detection. Unfortunately, many Americans are not aware of this important fact, and/or have difficulty in overcoming some natural reluctance that serves as a major impediment to screening. This lack of knowledge or commitment contributes to the lethal toll of colorectal cancer. We hope you may be willing to work with the American College of Gastroenterology in advancing public education about colorectal cancer, and as we seek to promote screening for ourselves and our loved ones by prevention and early detection.

Background on the American College of Gastroenterology

The American College of Gastroenterology is an organization of 7,000 physicians involved in the diagnosis and treatment of digestive diseases and conditions. As such, our members are those who are most frequently involved in the prevention, diagnosis and non-surgical treatment of colorectal cancers. The College is a non-profit charitable organization. We dedicate a significant portion of our resources to support of research on colorectal cancer and other GI conditions. We encourage both public awareness about digestive conditions and their treatments, as well as providing advocacy with public health policymakers for better digestive health. We support and encourage federal support for research and education about colorectal cancer and other GI conditions.

The American College of Gastroenterology Has Already Made a Major Commitment to Colorectal Cancer Screening and Education

(1) Colorectal Cancer Screening

In 1993, the College made a commitment to advocacy for a national Medicare benefit for colorectal cancer screening. We were troubled by the tremendous anomaly that on one hand, the American Cancer Society and many others were recommending that all Americans over the age of fifty have regular colorectal cancer screening tests, but on the other hand, if a Medicare patient approached his/her physician to be tested, not only was the test not paid for, but the patient had to execute a Medicare waiver which made it appear that the test may not have been necessary. The College made a major commitment of time and resources to educating legislators, and working with leaders in both parties, most notably Reps. Ben Cardin (D-MD), Bill Thomas (R-CA), Bill Archer (R-TX), Michael Bilirakis (R-FL), and Senator Edward Kennedy (D-MA), we were successful--in August, 1997 Congress enacted and the President signed a national Medicare colorectal cancer screening benefit. Since the new law took effect as of January 1, 1998, all Medicare beneficiaries now are entitled to an annual fecal occult blood test, a flexible sigmoidoscopy once every four years, and high risk patients are entitled to receive a screening colonoscopy once every two years, as well as other follow-up tests and treatment as indicated.

(2) Public Education

The College's efforts extend beyond advocating colorectal cancer screening in the legislative arena. We have been actively involved in educating the public through a program of television and radio public service announcements, print advertisements, transit advertising, involvement in health fairs, and other innovative efforts to enhance public attention on this issue. Since the enactment of the new Medicare benefit, we are concentrating on making certain that primary care physicians know about the new benefit. We are very active in a program to place our informational brochure, "Medicare Now Covers A Test That Could Save Your Life," in physician office waiting rooms throughout the country--over 600,000 copies have been placed since January, 1998.

Over the past few years, we have been very fortunate to have enlisted the support of a number of key public figures in these efforts, including:

President Ronald Reagan
Former HHS Secretary Louis Sullivan
Senator Charles Grassley (IA)
Senator Mitch McConnell (KY)
Rep. Henry Bonilla (TX)
Rep. Norman Sisisky (VA)

Rep. Tom Coburn (OK)

Rep. Karen Thurman (FL)

Rep. Rick Lazio (NY)

*Dr. La Jalle Leffall, Retired Chief of Surgery at Howard University and Past
President of: American Cancer Society*

United Way

American College of Surgeons

How Can You Contribute to This Effort? What Would You Be Asked to Do?

The College would very much like to have you involved in these efforts to the greatest extent to which you feel comfortable, and which your time permits. Our television, radio and print public service announcement program has been very successful, and the first step that we would suggest would be preparing a 30-second PSA, together with radio and print messages which we would circulate and promote. Beyond that, you might consider whether you would be willing to appear before Congress to testify on the need for screening, research and education about colorectal cancer, and perhaps some well-selected media communications on these same topics. We believe that the College shares with you a commitment to informing people about colorectal cancer, and how they can minimize its potential impact on themselves and their families. We are very flexible, and certain that working together, we could identify involvements that would respect your other commitments, but nonetheless have a meaningful impact in this critical area.

Conclusion

We have included a collection of some of the background materials we have prepared, as well as other initiatives in which we have been involved. Mr. Thomas Fise, the College's Executive Director, will initiate a follow-up contact with your office next week, to answer any questions you may have, and in the hopes that you may make your self available to support our efforts.

Eric Davis
Public Service Announcement
Colon Cancer
"Back in the Game"

:30 seconds

I'm Eric Davis. Colon cancer took me out of the game for part of the baseball season last year.

[Walking along a wall of head shots of well known individuals who've faced colon cancer.]

I'm not alone -- it's America's number 2 cancer killer. Behind that statistic are some of the faces of people whose lives have been touched by colon cancer.

African-Americans are twice as likely to die from colorectal cancer as other Americans--mainly because fewer are screened regularly and so cancers are detected later. Virtually all colorectal cancer deaths could be avoided with regular screening and removal of precancerous polyps. Fortunately, beginning in 1998, colorectal cancer screening is now covered for Medicare beneficiaries.

If you're over 50, see your doctor. Take the time to screen for colon cancer -- so it won't take you out the game.

Letter of Introduction to TV Stations for Public Service Announcement

Dear _____ :

Last year my baseball season was shortened when I learned that I had colon cancer. If it hadn't been detected then, it could have shortened my life. I'm back in the game now. I hope that my victory over colon cancer will help others by raising awareness of the importance of screening and early detection.

Working with a national physician organization, the American College of Gastroenterology, I have produced a television public service announcement, and I urge your station to join me in my campaign to educate the public about colon cancer by airing this important message.

Because colon cancer is not often discussed, few people realize that it is the second leading cancer killer in the United States -- more than either breast or prostate, only lung cancer claims more lives. This year, 130,000 new cases will be detected and 55,000 Americans will die from this disease. With routine screening, we can prevent colon cancer by removing pre-cancerous growths (or polyps.) With early detection we can diagnose cancers before they have a chance to spread. This is a powerful prevention message, one I hope your station will help deliver to the public.

My partner in this educational effort is the American College of Gastroenterology, a not-for-profit physician organization dedicated to educating Americans about the importance of colon cancer screening. I urge your station to join us by helping to get the word out about colon cancer screening by broadcasting this public service announcement. By working together, I believe we can be effective in spreading this lifesaving message. Please let me know if your station will broadcast these messages. Thank you for your help.

Sincerely,

Eric Davis
Baltimore Orioles



June 16, 1998

Ms. Neera Tanden
Associate Director for Domestic Policy
The White House
Washington, D.C. 20500

Dear Neera,

Thank you for inviting the American College of Radiology to participate in your initial discussions regarding the promotion of colorectal cancer screening. The College is pleased to be working with President and Mrs. Clinton, as well as the other interested groups, to publicize this life-saving examination.

As promised, I have included colorectal screening materials prepared by the College. I hope they will be useful to you. If you have any questions regarding this or any other matter, please do not hesitate to contact me.

Thank you again for your leadership in promoting colorectal cancer screening.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joshua J. Cooper'.

Joshua J. Cooper
Assistant Director,
Government Relations

enclosures



What are the symptoms?

In the early stages, there *are* no symptoms. That's why regular screening is so important. As the cancer progresses, any of the following symptoms may be present:

- Persistent change in bowel movement patterns
- Bleeding from the rectum or blood in the stool
- Vague abdominal discomfort
- Severe abdominal pain
- Unexplained weight loss
- Signs of bowel obstruction

Who is at risk?

Anyone over age 50 without other risk factors is at average risk for developing colorectal cancer. People with a family history of colon cancer and those with a history of prior polyps are at increased risk. Patients with a history of inflammatory bowel disease or an inherited colon cancer disorder are at high risk.

What causes colon cancer?

Nobody knows exactly, but some experts think that a high fat diet increases your chances of developing the disease while a high fiber diet decreases your susceptibility. Genetic factors also contribute. People with a family member who has had colon cancer are considered at higher risk. Colon cancer develops when the body's cells fail to grow in a normal way. This abnormal growth produces a tumor, which can be benign (not cancerous) or malignant (cancerous). Almost all cases of colon cancer start as benign polyps. These polyps can turn into cancer. Fortunately, the average time it takes for a polyp to become a cancer is 10 years. Because the disease progresses slowly, there is good opportunity for discovery and intervention.

How is colon cancer treated?

Detection and removal of the polyps from which most colon cancers arise may prevent cancer from developing. Early colon cancer is easy to treat and chance for full recovery is good. As it progresses though, treatment options are more limited, the chance for survival. Early-stage colon cancer is usually treated by removing the section of the colon that contains the tumor. Permanent colostomy (artificial opening to remove waste from the body) is not necessary unless the tumor is located in the rectum. This is rare. Treatment for late-stage colon cancer usually requires radiation therapy or chemotherapy in addition to the surgery.

If you have any of these problems, you should see your doctor immediately.

Medicare Screening Options Available

AVERAGE-RISK INDIVIDUALS

(no known risk factors — begin at age 50)

Double Contrast Barium Enema Every 4 Years — The only full anatomic examination of the colon and rectum available to average-risk persons. A series of x-rays shows several views of the colon so that polyps or cancers can easily be seen. It has a very low risk of colon damage. Patients can resume normal activities after completing the test.

Flexible Sigmoidoscopy Every 4 Years — A flexible scope examines the lower portion of the colon, where up to half of the cancers and polyps develop. Cancers and polyps in the upper half of the colon can be missed. The test can be performed comfortably and doesn't require sedation. Patients can resume normal activities after completing the test.

Fecal Occult Blood Test Yearly — Samples of stool are collected over a 3-day period and tested for the presence of blood. Since not all cancers and few polyps bleed, many lesions can be missed. The test is low-cost, noninvasive, and can be done at home. Positive tests require double contrast barium enema or colonoscopy for further evaluation.

INCREASED-RISK INDIVIDUALS

(family history of colorectal cancer, personal history of prior polyps/cancer — begin at age 40)

Double Contrast Barium Enema Every 2 Years — A full anatomic examination of the colon and rectum using a series of x-rays. It is noninvasive and does not require sedation. The risk of colon damage is very low. Patients can resume normal activities after completing the test.

Colonoscopy Every 2 Years — A full anatomic examination of the colon and rectum using a flexible scope. Sedation is required for most patients to alleviate discomfort. Most patients must be driven home and cannot resume normal activities several hours. Polyps can be removed during the procedure. There is a greater risk of damage to the colon compared to the other tests. This test is preferred for people with inflammatory bowel disorders of the colon and those with inflammatory bowel disease, and may be required before age 40.

Colon cancer is second only to lung cancer as America's leading cause of cancer death. This year alone, approximately 60,000 Americans will die from the disease. 160,000 new cases will be diagnosed. An average person has a 1 in 20 chance of developing colon cancer at some point in his or her life. Colon cancer affects men and women equally—

About 75% of all new colon cancers occur in people with no risk factors other than age.

in fact, more women over age 75 die from colon cancer each year than from breast cancer.

Its high mortality rate is shocking because colon cancer is one of the most easily prevented cancers. Not only that, but it also has a very high cure rate when detected early.

About 75% of all new colon cancers occur in people with no risk factors other than age. That's why regular screening is so important.

Talk to your doctor about colon cancer screening

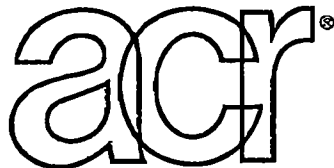
Plan to start regular examinations at the recommended age and repeat them at the intervals suggested. You can help prevent colon cancer by having regular colon cancer screening tests.

American Cancer Society guidelines suggest that average-risk individuals should be tested once every 5 years, while those at high risk for colon cancer should be screened every 3 years.

COLON CANCER

Why is early detection so important?

According to the American Cancer Society, when colon cancer is found early and hasn't spread, the patient has a 91% chance of survival. Unfortunately, only 37% of colon cancers are found at this stage. Once the cancer has spread to the nearby organs or lymph nodes, the chance of survival decreases considerably. Once it spreads to other parts of the body, the chance of survival is only 7%.



AMERICAN COLLEGE OF RADIOLOGY
1851 Preston White Drive • Reston, VA 20191
Phone: 703-648-8928 • E-mail: pr@acr.org

COLON CANCER



Protect Yourself
with
Regular Screening

AMERICAN COLLEGE OF RADIOLOGY

June 16, 1998

Ms. Neera Tanden
Associate Director for Domestic Policy
The White House
Washington, D.C. 20500

Dear Neera,

Thank you for inviting the American College of Radiology to participate in your initial discussions regarding the promotion of colorectal cancer screening. The College is pleased to be working with President and Mrs. Clinton and the other interested groups to publicize this life-saving ~~procedure~~. 

As promised, I have included colorectal materials prepared by the College. I hope they will be useful to you. If you have any questions regarding this or any other matter, please do not hesitate to contact me.

Thank you again for your leadership in promoting colorectal cancer screening.

Sincerely,

Joshua J. Cooper
Assistant Director,
Government Relations

Colorectal Cancer Screening: A Background Report

On January 1, 1998 the Health Care Financing Administration (HCFA) began covering a variety of colorectal cancer (CRC) screening tests. This new policy was published as a federal rule, which followed enactment of the Balanced Budget Act of 1997. Prior to this rule, Medicare did not reimburse screening tests for CRC.

Under the rule, average-risk patients can now choose among the following options: fecal occult blood test (FOBT), flexible sigmoidoscopy, or barium enema. FOBT is an indirect test that will detect 1/3 of cancers and 10 percent of the lesions (precursor adenomas) that could eventually become cancerous. Flexible sigmoidoscopy examines half of the colon. Barium enema examines the entire colon and rectum.

For patients at high risk for CRC (e.g. those with an immediate family member who has had the disease or those patients who have had a history of colon neoplasms) barium enema and colonoscopy are covered.

Following is background information on colorectal screening gathered by the American College of Radiology.

Fecal occult blood tests have the advantage of being relatively low in cost, non-invasive and portable, but have been proven to be an ambiguous marker for colorectal neoplasia. Most asymptomatic cancers and the vast majority of pre-malignant adenomas do not bleed, and most bleeding arises from minor, non-neoplastic sources. Therefore, sensitivity and specificity are negatively affected. When compared against full structural examinations, hemoccult sensitivity has averaged less than 30 percent for asymptomatic CRC and less than 12 percent for larger adenomas. FOBT specificity has generally ranged from 90-95 percent, which means that those patients screened have up to a 1 in 10 chance of producing a false-positive test and undergoing unnecessary colonoscopy.

There is evidence of a small mortality benefit from FOBT screening. This reduction appears largely attributable to the detection of early-stage cancers, but not adenomas. This reduces the chances for effective prevention. Case-control studies on FOBT screening have shown conflicting results, with some indicating a small reduction and others no effect at all on CRC mortality. Patient compliance with the test has averaged from 50-70 percent in trials, but less than 30 percent in most community programs.

Flexible sigmoidoscopy, according to case-control studies, has led to a marked reduction in CRC mortality. Unlike FOBT screening, it detects precursor adenomas. As a result, the incidence of CRC should be reduced with sigmoidoscopy screening, and the benefit on CRC mortality may be retained with screening as infrequently as every 10 years. Sigmoidoscopy is, however, limited to the left colorectum. Most right-sided cancers are not associated with synchronous left-sided polyps that would trigger a more proximal examination. Sigmoidoscopic screening, therefore, will fail to detect at least half of all CRCs.

Barium enema displays the entire colorectum and can detect precursor adenomas. Visualizing the entire colorectum is highly desirable and generally considered the best way to evaluate the colon.

The risk of perforation from barium enema is less than 1 in 25,000, or 25 times lower than the risk from colonoscopy, and as much as 5 times lower than the same risk for flexible

sigmoidoscopy. Patients are not sedated for this test. They are exposed to 300-500 mrad of radiation – about the same dose of radiation as mammography. Several large, prospective studies, in which consecutive patients received both barium enema and endoscopy, have assessed the performance of barium enema. While no testing was performed on asymptomatic screening populations, the methodology is sound for assessing the performance of barium enema in community populations seeking medical attention. Steine, et al., evaluating 190 patients, found that the sensitivity and specificity of double contrast barium enema (DCBE) for the detection of polyps > 1 cm (the broadly accepted target lesion size for screening populations) were 81 percent and 96 percent, respectively. No cancers were missed in this group.

Saito and co-workers found that in a study of the left side of the colon, involving 675 consecutive patients, no cancers were missed by DCBE and the sensitivity for polyps > 1 cm was 87.5 percent. Rex, et al., in a blind, prospective study to determine the sensitivity of the DCBE in detecting left-sided colonic polyps, reported a 100 percent sensitivity for polyps > 1 cm.

Colonoscopy, although a superior method for full anatomic colorectal evaluation, has not been considered for CRC screening in the general population due to its risk of morbidity and mortality and its much greater expense. This detection method requires sedation. It is associated with patient discomfort, as is barium enema.

While prospective trials in groups of patients at high risk for CRC have shown that colonoscopic polypectomy reduces CRC incidence, incomplete examinations occur in 10-15 percent of patients. The ability to remove many identified colon lesions using this procedure has been documented. However, routine screening of the population at regular intervals would not only be enormously expensive but could also increase morbidity and mortality because of risks associated with the examination.

Many experts consider colonoscopy and DCBE equivalent in diagnosing cancer and polyps > 1 cm. A recent report from the American Gastroenterological Association (AGA) states:

"...while colonoscopy detects more small polyps, there is little difference in the ability of these tests (colonoscopy and barium enema) to detect large polyps (> 1 cm in diameter)."

False positive rates and rates of inadequate examinations are about the same for the two procedures. Further, the U.S. Preventative Services Task Force states:

"...colonoscopy and barium enema...appear to have comparable accuracy."

Cost differences between barium enema and colonoscopy are illustrated in current Medicare reimbursement rates. For

the screening of high-risk patients in the outpatient setting, DCBE (including the costs of follow-up biopsy with colonoscopy in 10-12 percent of this population), is approximately one-third of the total cost of a colonoscopy examination. In an office setting, DCBE is just over 50 percent of the cost of colonoscopy. Eddy and colleagues, in 1987, used a mathematical model to estimate the cost effectiveness of colorectal screening strategies for people at high risk. The barium enema was found to be the most cost-effective strategy when compared with FOBT and sigmoidoscopy, alone or in combination.

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What HCFA Says about Colorectal Cancer (CRC) Screening

A new rule established by the Health Care Finance Administration (HCFA) and published in the Federal Register says:

- ✓ Medicare now covers barium enema as an alternative screening test for CRC.
- ✓ Patients at *average risk* for CRC can choose fecal occult blood testing (FOBT), flexible sigmoidoscopy or double contrast barium enema (DCBE) as CRC screening tests.
- ✓ Patients at *high risk* for CRC (i.e. those with a family history of the disease) can choose either colonoscopy or DCBE as a CRC screening test.
- ✓ Double Contrast Barium Enema (DCBE) is the standard screening enema covered by Medicare.
- ✓ Major advantages of DCBE include imaging of the entire colon and detection of precursor adenomas as well as CRCs.
- ✓ The American College of Radiology estimates that a DCBE every 2-4 years results in less radiation than a standard screening mammogram.
- ✓ DCBE appears to be safer than flexible sigmoidoscopy or colonoscopy.
- ✓ DCBE is an alternative to flexible sigmoidoscopy as a substitute—not as an additional benefit—for patients 50 and older who are not at high risk for CRC. As with other diagnostic radiological tests, a written referral from the patient's primary care physician is required.
- ✓ Average-risk patients should have a DCBE once every 48 months.
- ✓ High-risk patients should be screened once every 24 months. A physician can order a DCBE instead of a colonoscopy.

Colorectal Cancer (CRC) Screening: Answers to Commonly Asked Questions

Q: Why is CRC screening an issue today?

A: CRC is the second most common fatal cancer in the United States today. Detection and removal of adenomatous polyps and early cancers has been shown to reduce the incidence and mortality from CRC. Recent guidelines from multi-disciplinary panels and the American Cancer Society now recommend screening of the general population. Medicare now covers CRC screening for eligible recipients.

Q: What patients are covered by Medicare for screening?

A: Patients who are currently insured by Medicare are eligible for this new benefit. Average-risk patients (those without a family history of CRC) are eligible for screening every four years. High-risk patients (those with a first degree relative with CRC or those who have had a history of colon neoplasms) are eligible for screening every two years.

Q: What tests are covered by Medicare for CRC screening?

A: For patients at average risk for CRC, physicians and their patients can choose either fecal occult blood testing, flexible sigmoidoscopy, or barium enema. For patients at higher risk, either a barium enema or colonoscopy are approved procedures.

Q: What type of barium enema procedure should be performed?

A: The double-contrast barium enema (DCBE) is the standard covered examination. The single-contrast barium enema is covered if the patient is immobile, infirm, or debilitated.

Q: Can the barium enema procedure be performed with flexible sigmoidoscopy for average-risk patients or in conjunction with colonoscopy for high-risk patients?

A: Only one screening procedure is reimbursed. Physicians and their patients must determine which single examination is best for them.

Q: What does the attending physician need to do to order a DCBE and comply with the new HCFA regulation?

A: The attending physician is required to send a written referral calling for a barium imaging test to the radiologist. That is, the rule asks no more of physicians than to use accepted practice standards to determine the best CRC screening test for a given patient. No further documentation is necessary.

Q: What is the expected performance of the double-contrast barium enema?

A: The performance of the barium enema has been assessed prospectively in several large studies in which consecutive patients received both double-contrast barium enema and colonoscopy. Steine, et al. evaluated 190 patients and found that the sensitivity and specificity of the double-contrast barium enema for the detection of polyps >1 cm (accepted target lesion for screening populations) were 81% and 96%,

respectively. No cancers were missed in this group. Saito and co-workers found that in a study of the left side of the colon, involving 675 consecutive patients, no cancers were missed by the double-contrast barium enema and the sensitivity for polyps > 1 cm was 87.5% with a specificity of 96%. These studies indicate that the barium enema performed in community settings can be highly accurate. The U.S. Preventative Services Task Force report also indicates that the performance of the barium enema and colonoscopy are similar for the detection of polyps and cancer.

Q: What advantages does the DCBE have over other authorized screening tests?

A: The DCBE is an accurate, cost-effective, full structural examination of the colorectum. Flexible sigmoidoscopy only examines the distal half of the colorectum at best. Colonoscopy is the most expensive of the tests, carries the highest risk of bleeding or perforation (at least 25 times higher than DCBE), and usually prevents patients from driving or returning to work the day of the examination because of routinely administered sedation.

Q: What are the potential savings to payors if DCBE is performed instead of colonoscopy for high-risk patients?

A: DCBE has been repeatedly shown to be one of the most cost-effective CRC screening tests. Procedural costs using Medicare fees for hospital outpatient services are 4 times higher for colonoscopy than DCBE, according to HCFA. This cost difference does not include the cost of time lost for work due to sedation at colonoscopy or the cost of additional drivers to transport a patient to and from the colonoscopic procedure.

Q: What opportunities exist for me to refresh my knowledge and skills in performing and interpreting the DCBE?

A: The ACR has a number of resources through which its members may refresh their barium enema skills. These include:

- CD-ROM produced by the ACR on interpretation of the DCBE.
- Speakers Bureau with regional experts available to address either a radiology or primary care physician audience.
- Minifellowships with 1-2 day programs for direct observation of current techniques. *For additional information call the ACR at 800-227-5463, ext. 4798 or check the education section of the ACR website at www.acr.org.*
- Quality Control Manual slated for production later this year.

Q: What are considered biologically significant polyps to detect in a screening study?

A: All expert panels agree that targeted lesions should be 1 cm or larger. These lesions are easily detected using DCBE.

Model Letter

The ACR encourages members to use the following model letter and other information provided in this special section of The ACR Bulletin to inform referring physicians about the changes in colorectal cancer screening guidelines resulting from the beginning of Medicare coverage January 1, 1998:

Dear Dr. _____

I am writing to inform you of a recent change in Medicare reimbursement rules for colorectal screening tests. In the past only patients with colorectal symptoms could have a barium examination of the colon covered under Medicare. Beginning January 1, 1998, Medicare now covers screening tests for both average- and high-risk patients. The new coverage includes the following:

Average risk patients (those without any known colorectal cancer risk factors) $\geq$ age 50

- Fecal occult blood testing – covered annually
- Flexible sigmoidoscopy or double contrast barium enema (DCBE) – covered every 4 years

High risk patients (those with a family history [first degree relative, but not an inherited syndrome] of colorectal cancer or a personal history of colorectal polyp or cancer) $\geq$ age 40

- Fecal occult blood testing – covered annually
- Double contrast barium enema or colonoscopy – covered every 2 years

Physicians and patients should understand these options and select the best test for each individual circumstance. I believe the double contrast barium enema is an excellent option for many in both patient groups. For average-risk individuals the DCBE is the only covered full structural examination of the entire colorectum. For high-risk individuals the DCBE is a safe and cost-effective alternative to colonoscopy.

Expert panels convened by both the American Gastroenterological Association and the American Cancer Society have recently reviewed all of these colorectal screening tests. The barium enema has been recommended as an option for average- and high-risk individuals by both groups. The U.S. Preventative Services Task Force also stated that for the detection of lesions > 1 cm (the targeted lesion size for screening studies), the performance of the DCBE and colonoscopy were comparable.

The DCBE can be ordered in the usual fashion to facilitate Medicare coverage. Special certification for this testing option is not necessary.

I am excited about this new opportunity to bring colorectal screening to our community. We now know that detection and removal of precursor adenomatous polyps and early cancers will lower the mortality from colorectal cancer. Helping to eliminate this health menace can truly translate into a better life for our patients.

Very truly yours,

DID YOU KNOW?

Colorectal Cancer (CRC)

- causes 60,000 deaths each year in the USA
- second leading cause of cancer death in the USA
- 150,000 new cases diagnosed in 1996
- lifetime risk for developing CRC is 1 in 20
- average time for a colon polyp to become a cancer is 10 years
- each CRC prevented or found at an early stage increases individual life expectancy by 8 years

The latest national guidelines recommend total colonic screening of all individuals 50 years or older (earlier if at high risk). The most cost effective screening for the average risk patient is an annual Fecal Occult Blood Test and a Double Contrast Barium Enema every 5 years.

Double Contrast Barium Enema

- equally as effective as colonoscopy in detecting large polyps and cancer
- 25-50 times safer than colonoscopy
- takes less time than colonoscopy
- does not require sedation
- sees the complete colon more often than colonoscopy
- one fifth to one third of the cost of colonoscopy

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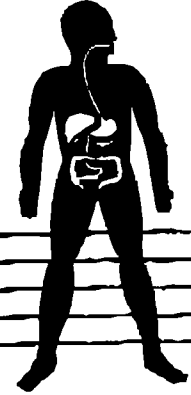
AGA

056 P02

AUG 12 '98 15:27

202-546-7105 HMCW DALE DIRKS

Gestive Disease National Coalition



507 Capitol Court, N.E., Suite 200, Washington, D.C. 20002
(202) 544-7497 (202) 546-7105 - Fax

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Olney Foundation for Home Parenteral and Enteral Nutrition
Pennsylvania Society of Gastroenterology
Society of Gastroenterology Nurses and Associates, Inc.
United Ostomy Association
Wound, Ostomy and Continence Nurses Society

ADMINISTRATION
Health & Medicine Council of Washington
DALE P. DIRKS

Founder & President Emerita
Suzanne Rosenthal

AUGUST 12, 1998

MEMORANDUM

TO: AMY MANELA

FR: DALE DIRKS

RE: LEGISLATORS FOR WHITE HOUSE CRC EVENT

I have checked with various Roundtable groups and collectively we have come up with the following list of legislators who have demonstrated an interest in colorectal cancer:

Sen. Edward Kennedy	(D-MA)	224-4543
Sen. Bob Graham	(D-FL)	224-3041
Sen. John Breaux	(D-LA)	224-4623
Sen. John Chafee	(R-RI)	224-2921

Address: United States Senate
Washington, D.C. 20510

Rep. Ben Cardin	(D-MD)	225-4016
Rep. John Lewis	(D-GA)	225-3801
Rep. Pete Stark	(D-CA)	225-5065
Rep. Louise Slaughter	(D-NY)	225-3615
Rep. Shearod Brown	(D-OH)	225-3401
Rep. Bill Thomas	(R-CA)	225-2915
Rep. Bill Archer	(R-TX)	225-2571
Rep. Michael Bilirakis	(R-FL)	225-5755
Rep. Nita Lowey	(D-NY)	225-6506
Rep. Norman Sisisky	(D-VA)	225-6365
Rep. Alcee Hastings	(D-FL)	225-1313

Address: United States House of Representatives
Washington, D.C. 20515

cc: Dr. Gabe Feldman

Hillary Clinton Colon Cancer PSA #1

30-second Script

Fade up on a medium wide shot of Hillary Clinton sitting at her desk. Family portraits are on the credenza behind her.

MRS. CLINTON:

We're all busy. But those of us 50 and older should **MAKE TIME** to get tested for colon cancer. It's the second leading cancer killer... and **WOMEN** get it nearly as often as men.

Camera starts slow zoom in to medium close up.

However, colon cancer is curable... **EVEN PREVENTABLE** when detected early.

People say they're embarrassed or too busy... or that they have no obvious symptoms or a family history. **BUT SCREENING SAVES LIVES.**

So **PLEASE...** get tested for colon cancer.

Dissolve to graphic with tollfree phone number.

[Production Note: Monologue must be no longer than 27 seconds to allow time for closing graphic with tollfree phone number]

Hillary Rodham Clinton Colon Cancer PSA #2

30-second Script

Fade up on a group of four women in their fifties as they are coming off a tennis court, rackets and towels in hand. They are the picture of what we all would like to be... energetic and fit. Close up of Woman #1 as we enter their conversation in mid stream...

Woman #1: *(Energetic and cheerful)*
OK, who's up for lunch?

Woman #2: *(shaking head no)*
I have to take Tim to the doctor.

Woman #3: *(concerned)*
Is everything OK?

Woman #2: *(at ease)*
Yeah, it's just a colon cancer test.

Woman #4:
But he's so young, only 52.

Woman #3:
I'm supposed to get screened too but I don't have the time.

Fade to white, then fade to a medium wide shot of Hillary Clinton at her desk. Family portraits are in the background. She feels like a good friend telling us something that might be hard to hear, yet must be discussed.

Mrs. Clinton: *(addressing camera)*
Colon cancer is the **SECOND LEADING** cancer killer... and **WOMEN** get it nearly as often as men.

Camera starts slow zoom in to medium close up.

But colon cancer is curable... **EVEN PREVENTABLE** when detected early.
So if you're 50 or older... **PLEASE**, get tested for colon cancer.

Dissolve to graphic with tollfree phone number.

[Production Note: Mrs. Clinton's section must be no longer than 13 seconds to allow it to also serve as a 15-second PSA with a closing graphic.]

Hillary Rodham Clinton Colon Cancer PSA #3

60-second Script

Fade up on a group of four women in their fifties as they are coming off a tennis court, rackets and towels in hand. They are the picture of what we all would like to be... energetic and fit. Close up of Woman #1 as we enter their conversation in mid stream...

Woman #1: *(Energetic and cheerful)*
OK, who's up for lunch?

Woman #2: *(shaking head no)*
I have to take Tim to the doctor.

Woman #3: *(concerned)*
Is everything OK?

Woman #2: *(at ease)*
Yeah, it's just a colon cancer test.

Woman #4:
But he's so young, only 52.

Woman #3:
I'm supposed to get screened too but I don't have the time.

Fade to white, then fade to a medium wide shot of Hillary Clinton at her desk. Family portraits are in the background. She feels like a good friend telling us something that might be hard to hear, yet must be discussed.

MRS. CLINTON:
We're all busy. But those of us 50 and older should **MAKE TIME** to get tested for colon cancer. It's the second leading cancer killer... and **WOMEN** get it nearly as often as men.

Camera starts slow zoom in to medium close up.

However, colon cancer is curable... **EVEN PREVENTABLE** when detected early.

So what's keeping you? People say they're embarrassed or too busy... or that they have no obvious symptoms or a family history. **BUT SCREENING SAVES LIVES.**

So **PLEASE...** get tested for colon cancer.

Dissolve to graphic with tollfree phone number.

[Production Note: Mrs. Clinton **DOES NOT** have to tape this PSA. It will be produced in the edit room using PSAs #1 and #2.]

Hillary Clinton Colon Cancer PSA #2
30-second Script

*Her
Gripes*

Fade up on a group of four women in their fifties as they are coming off a tennis court, rackets and towels in hand. They are the picture of what we all would like to be... energetic and fit. Close up of Woman #1 as we enter their conversation in mid stream...

Woman #1: *(Energetic and cheerful)*
OK, who's up for lunch?

Woman #2: *(shaking head no)*
I have to take Tim to the doctor.

Woman #3: *(concerned)*
Is everything OK?

Woman #2: *(at ease)*
Yeah, it's just a colon cancer test.

Woman #4:
But he's so young, only 52.

Woman #1: *(confused)*
My doctor even told ME to get screened, but I thought only men get it.

Woman #3:
I'm supposed to get screened too but I don't have the time.

Fade to white, then fade to a medium wide shot of Hillary Clinton sitting on the couch in her family room. Family portraits are in the background. She is relaxed, yet somewhat firm. She feels like a good friend telling us something that might be hard to hear, yet must be discussed.

Mrs. Clinton: *(addressing camera)*
These excuses could cost you your life.

Camera starts slow zoom in.

Colon cancer is the second leading cancer killer... and women get it as often as men. But it's curable or even preventable when detected early. If you are 50 or older, get tested for colon cancer.

Zoom is complete. Mrs. Clinton on medium close up.

~~No More Excuses.~~

American
Digestive
Health
Foundation



Facsimile Cover Sheet

ADHF, 7910 Woodmont Ave., Suite 700, Bethesda, MD 20814

To: Neera Tanden

From: Carole Anikis

Company: American Digestive Health Foundation

Phone: (301)941-2626

Fax: (301)654-5920

Email canikis@gastro.org

Date: July 20, 1998

Pages including 3

this cover page:

FYI, attached is what we sent to Michael O'Mary, in response to his request for plans to roll out colon cancer PSA.

To: Michael O'Mary
From: Amy Manela
Subject: Colorectal Cancer PSA Roll-Out
Date: July 20, 1998

According to Neera Tanden, the White House plans to hold a special event, tentatively scheduled for September 10, during which the PSA will be introduced. Following is a summary outlining our release and distribution of Mrs. Clinton's public service announcement focusing on colorectal cancer (CRC).

Television

- Satellite feed on September 10 (following the event). Will fax a pre-release notification to stations nationwide, which will provide coordinates.
- 1,100 videotapes will be mailed to every broadcast outlet that uses national PSAs including networks (ABC, NBC, CBS, Fox, Warner, United Paramount) and 37 national cable networks (CNN, A&E, Discovery, Learning Channel, etc.)
- National Association of Broadcasters closed circuit feed (October '98)
- Satellite feed via PSA Channel to 700 stations across the country (October '98)
- Video News Release: We will develop a 90-second news feature focusing on the launch of the new PSA, as well as the lack of awareness of the need for screening, as supported by survey results released at the event. If possible, we also will include footage from the White House event. Distribution will include satellite feed and mailing to news departments nationwide.

Radio

- Mailing of PSA to 4,000 radio stations nationwide. Also, to extend reach, we could produce an audio news release, featuring a designated spokesperson, to discuss survey results and PSA release.

Print

Mailing of print PSA to 6,000 daily and weekly newspapers, as well as men's, women's and health magazines.

Colon Cancer PSA Roll-out/Page 2

Mailings

- Statistics on CRC prevalence by state will be developed and provided to public service directors. Timing of receipt of PSA by mail is projected to be:
 - east coast - three days after the event
 - mid-west - five days after the event
 - west coast - seven days after the event

Supplemental Efforts

- All organizational members of the National CRC Roundtable (approx. 30) will promote the availability of the PSA via their newsletters, websites and meetings.
- Will exhibit PSA at the National Broadcast Association for Community Affairs Conference (October '98)
- Will provide PSA to National Association of Broadcasters and pitch its use in NAB's monthly closed circuit feed to members.
- PSA will be featured on the front page of *Broadcaster Café*, an 1,100 circulation trade publication distributed to TV public service directors. □



FAX COVER SHEET

NATIONAL HOME OFFICE

3 Pages to Follow

TO: Ms. Neera Tanden DATE: 7-17-98
FROM: Carole Carl TIME: 7:30 P
SUBJECT: National Colorectal Cancer 12/T test
MESSAGE: to follow is list you
requested
any guests feel free
to call me

CAROLE CARL

404/329-7631; FAX 404/248-1780

Cancer Control Department - 5th Floor
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National Colorectal Cancer Roundtable

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National Colorectal Cancer Roundtable

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FAX COVER PAGE

TO: Neera Tanden
FAX NUMBER: 6-2878

FROM: Billy Mann
PHONE NUMBER: 6-7288

TOTAL PAGES (Including cover page): 3

COMMENTS:

Neera, here are the revised copies of the colon cancer drafts. In order to reduce the time and clarify the language, the phrase "even preventable" has been removed in both drafts after the phrase "colon cancer is curable." Also, if the script is too long, we'll probably remove the phrase "or too busy" which is in parentheses.

Call me if you have any questions.

**FIRST LADY HILLARY RODHAM CLINTON
VIDEOTAPE REMARKS FOR
30 SECOND COLON CANCER PSA
JULY 21, 1998**

We're all busy. But those of us 50 and older should make time to get tested for colon cancer. It's the second leader cancer killer--and women get it nearly as often as men.

However, colon cancer is curable when detected early.

People say they're embarrassed [or too busy] or that they have no obvious symptoms or a family history. But screening saves lives.

So please, get tested for colon cancer.

**FIRST LADY HILLARY RODHAM CLINTON
VIDEOTAPE REMARKS FOR
15 SECOND COLON CANCER PSA
JULY 21, 1998**

Colon cancer is the second leading cancer killer--and women get it nearly as often as men.

But colon cancer is curable when detected early.

So if you're 50 or older, please get tested for colon cancer.

Private Industry Partnerships To Be Announced at White House Event

The National Colorectal Cancer Roundtable is seeking partnerships with private industry to raise awareness of the importance of colorectal cancer screening and prevention. These partnerships will be announced at a major White House event on September 10, 1998. At this event, First Lady Hillary Rodham Clinton will unveil her support for raising awareness of colorectal cancer screening and prevention.

Colorectal cancer is the second leading cancer killer and everyone aged 50 and older is at risk. More than 50,000 Americans will die from colon cancer this year and 131,600 new cases will be diagnosed. Men and women are affected almost equally.

However, colorectal cancer is *preventable* – even *curable* when detected early. In fact, if the cancer is found early enough, the patient has more than a 90 percent chance of survival. Widespread screening for colorectal cancer could reduce the death rate by over 50 percent. *There is no other disease about which we can make this claim.*

Our goal with these partnerships is to communicate to people over the age of 50 that they should get tested for colorectal cancer. You can help us to spread this important message to your employees and customers through:

- Employee communication vehicles such as newsletters, bulletin boards, mailings, and staff meetings
- Incorporating information on colorectal cancer screening and prevention into your employee wellness programs
- Printing messages about the importance of prevention and screening on, or including them with, the products or services you provide to your customers

As a partner in this effort, you will receive broad recognition. We will contact you shortly to determine your interest in joining us on this most important, life-saving campaign. In the meantime, if you have any questions, please call Amy Manela at the American Digestive Health Foundation at (301) 941-2628.

American
Digestive
Health
Foundation



Facsimile Cover Sheet

ADHF, 7910 Woodmont Ave., Suite 700, Bethesda, MD 20814

To: Barbara Woolley
Neera Tanden

From: Carole Anikis
Company: American Digestive Health Foundation
Phone: (301)941-2626
Fax: (301)654-5920
Email canikis@gastro.org

Date: August 7, 1998

Pages including 2
this cover page:

Following is a draft description of the White House partnership effort. We put Amy in as the contact on this draft, but can insert the name of whomever you prefer to be the point person. Just let me know.

cc B. Levin, MD
J. Bond, MD
G. Feldman, MD

DRAFT

White House Private Industry Partnerships

The White House is seeking partnerships with private industry to raise awareness of the importance of colorectal cancer screening and prevention. Colorectal cancer is the second leading cancer killer and everyone aged 50 and older is at risk. More than 50,000 Americans will die from colon cancer this year and 131,600 new cases will be diagnosed.

However, colorectal cancer is *preventable* – even *curable* when detected early. In fact, if the cancer is found early enough, the patient has more than a 90 percent chance of survival. Widespread screening for colorectal cancer could reduce the death rate by over 50 percent. *There is no other disease about which we can make this claim.*

Our goal with these partnerships is to communicate to people over the age of 50 that they should get tested for colorectal cancer. You can help us to spread this important message to your employees and customers through:

- Employee communication vehicles such as newsletters, bulletin boards, mailings, and staff meetings
- Incorporating information on colorectal cancer screening and prevention into your employee wellness programs
- Printing messages about the importance of screening on, or including them with, the products or services you provide to your customers

These partnerships will be announced at a major White House event on September 10, 1998. At this event, First Lady Hillary Rodham Clinton will unveil her support for raising awareness of colorectal cancer screening and prevention. As a partner in this effort, you will receive broad recognition.

We will contact you shortly to determine your interest in joining us on this most important, life-saving campaign. In the meantime, if you have any questions, please call Amy Manela at the American Digestive Health Foundation at (301) 941-2628.

American
Digestive
Health
Foundation



Facsimile Cover Sheet

ADHF, 7910 Woodmont Ave., Suite 700, Bethesda, MD 20814

To: Neera Tanden

From: Carole Anikis

Company: American Digestive Health Foundation

Phone: (301)941-2626

Fax: (301)654-5920

Email canikis@gastro.org

Date: August 10, 1998

**Pages including 9
this cover page:**

Here's the information we propose sending to Debbie Pike and Jeff Zucker. Please let me know if it's ok.



"I feel fine."

"My schedule is too hectic."

"I'm only 50."

**MAKE THE TIME TO GET
A TEST THAT COULD SAVE
YOUR LIFE.**

Colon cancer is the second-leading cancer killer and everyone aged 50 and older is at risk. More than 50,000 Americans will die from colon cancer and 131,600 new cases will be diagnosed this year.

Colon cancer is an equal-opportunity disease that affects both women and men. This silent killer frequently begins without symptoms and those with a family history are at even greater risk.

THE GOOD NEWS IS:

Colon cancer is preventable—even curable when detected early. In fact, if cancer is found early enough, the patient has more than a 90 percent chance of survival.

Colon cancer screenings are safe and effective and are now covered by Medicare. There's even a test that can be used in the privacy of your own home.

Talk to your doctor about getting tested.



"You can prevent colon cancer, even beat it."

• HILLARY CLINTON •

**FOR MORE INFORMATION, CALL THE AMERICAN CANCER SOCIETY
AT 1-800-ACS-2345**

Hillary Rodham Clinton Colon Cancer PSA #1
30-second Script

Quick fade up on a medium wide shot of Hillary Clinton. Books and a family portrait are behind her.

MRS. CLINTON:

Were all busy, but if you're 50 and older you should make time to get tested for colon cancer which kills over 50,000 people a year and strikes women nearly as often as men.

Camera starts slow zoom in to medium close up.

But you can beat cancer and even prevent it, if it is detected early.

People have all sorts of reasons for not getting tested. They may be too embarrassed or have no symptoms or a family history.

But there is one powerful reason to get screened for colon cancer. It can save your life.

So please, get tested now.

Quick fade to black.

Hillary Rodham Clinton Colon Cancer PSA #2
30-second Script

Fade up on a group of four women in their fifties as they are coming off a tennis court, rackets and towels in hand. They are the picture of what we all would like to be... energetic and fit. Close up of Woman #1 as we enter their conversation in mid stream...

Woman #1: *(Energetic and cheerful)*
OK, who's up for lunch?

Woman #2: *(shaking head no)*
I have to take Tim to the doctor.

Woman #3: *(concerned)*
Is everything OK?

Woman #2: *(at ease)*
Yeah, it's just a colon cancer test.

Woman #4:
But he's so young, only 52.

Woman #3:
I'm supposed to get screened too but I don't have the time.

Fade to white, then fade up on a medium wide shot of Hillary Clinton. Books and a family portrait are behind her.

MRS. CLINTON: *(addressing camera)*
Colon cancer kills over 50,000 people a year and strikes women nearly as often as men.

Camera starts slow zoom in to medium close up.

But you can beat it, if it's detected early.

So if you're 50 or older, please get tested. It can save your life.

Fade to graphic with toll-free phone number (2-seconds).

Limelight Communications, Inc.

Hillary Rodham Clinton Colon Cancer PSA #3
60-second Script

Fade up on a group of four women in their fifties as they are coming off a tennis court, rackets and towels in hand. They are the picture of what we all would like to be... energetic and fit. Montage of shots of doubles playing. The final slice finishes the game. Close up of Woman #1 as the women head off the court.

Woman #1: *(Energetic and cheerful)*
OK, who's up for lunch?

Woman #2: *(shaking head no)*
I have to take Tim to the doctor.

Woman #3: *(concerned)*
Is everything OK?

Woman #2: *(at ease)*
Yeah, it's just a colon cancer test.

Woman #4:
But he's so young, only 52.

Woman #3:
I'm supposed to get screened too but I don't have the time.

Fade to white, then fade to a medium wide shot of Hillary Clinton at her desk. Family portraits are in the background.

MRS. CLINTON:
We're all busy, but if you're 50 and older you should make time to get tested for colon cancer which kills over 50,000 people a year and strikes women nearly as often as men.

Camera starts slow zoom in to medium close up.

But you can beat cancer and even prevent it, if it is detected early.

People have all sorts of reasons for not getting tested. They may be too embarrassed or have no symptoms or a family history.

But there is one powerful reason to get screened for colon cancer. It can save your life.
So please, get tested now.

Fade to animated graphic with toll-free phone number (4-seconds)

Hillary Rodham Clinton Colon Cancer PSA #4
15-second Script

Quick fade up on a medium wide shot of Hillary Clinton. Books and a family portrait are behind her.

MRS. CLINTON: *(addressing camera)*

Colon cancer kills over 50,000 people a year and strikes women nearly as often as men.

Camera starts slow zoom in to medium close up.

But you can beat it, if it's detected early.

So if you're 50 or older, please get tested. It can save your life.

Fade to graphic with toll-free phone number (2-seconds).

**Survey Questions of Older Americans' Awareness of Colorectal Cancer
Screening Procedures**

1. Have you ever been screened for colorectal cancer either as part of a general physical exam, or as a special procedure? Screening means having tests to detect a disease when you have no symptoms.
 1. Yes
 2. No
 3. Don't know/No answer/Refused
2. Has your personal physician ever recommended that you be screened for colorectal cancer either as part of a general exam, or as a special procedure?
 1. Yes
 2. No
 3. Don't know/No answer/Refused
3. One screening method involves the use of paper cards at home to test for blood in the stool. Your doctor would have provided cards for you to take home to take a sample and then send it in for evaluation. Have you had this method of screening for colorectal cancer?
 1. Yes
 2. No
 3. Don't know/No answer/Refused
4. One screening method involves the use of an endoscope, which is a lighted tube that is inserted in the rectum so the doctor can look for abnormalities. This procedure is called a flexible sigmoidoscopy or colonoscopy. Have you had this method of screening for colorectal cancer?
 1. Yes
 2. No
 3. Don't know/No answer/Refused
5. One screening method is called a barium enema, an x-ray examination after you have had an enema with barium which allows the doctor to visualize the inside of the colon. Have you had this method of screening for colorectal cancer?
 1. Yes
 2. No
 3. Don't know/No answer/Refused