

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Prudence Squier to Bill Clinton re: phone numbers (partial) (2 pages)	02/04/2000	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20463

FOLDER TITLE:

Cancer Screening

2012-0463-S

rc725

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
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- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

**FAX TRANSMITTAL
OFFICE OF THE DIRECTOR
NATIONAL CANCER INSTITUTE**

DATE: March 8, 2000

TO: Mr. Chris Jennings

FAX: 202-456-5557

PHONE: 202-456-5594

FROM: RICHARD D. KLAUSNER, M.D.

Building 31, Room 11A48

National Cancer Institute, Bethesda, MD 20892

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Cover Sheet Plus 12 Pages Transmitted

AS requested - Talking Points on Colorectal Cancer

Talking Points on Colorectal Cancer

Background

- Cancers of the colon and the rectum are the second leading cause of cancer death in the United States. Among all cancers, only lung cancer claims more lives. An estimated 130,000 Americans will be diagnosed with colorectal cancer this year, and 56,000 will die from this disease.
- The lifetime risk of dying from colorectal cancer is about 2.5 percent. That is, one in forty Americans will die from colorectal cancer.
- Efforts to improve these figures have paid off, as death rates from colorectal cancer are falling and are at their lowest point in decades. And the risk of getting colorectal cancer has been declining steadily for almost 20 years.

Screening

- Screening more men and women once they reach age 50 would further reduce the number of colorectal cancer cases and deaths.
- There are a number of screening options:
 - A simple stool blood test (the fecal occult blood test, or FOBT) can be done at home and sent to your doctor once a year. The FOBT has been proven to reduce the number of deaths from colorectal cancer.
 - A sigmoidoscopy, which looks at the lower colon with a flexible scope, can also detect precancerous polyps and small cancers. Evidence suggests that having the test every 5 to 10 years can be highly effective.
 - A colonoscopy, where specialists examine the entire colon, can also detect precancerous polyps and small cancers. A colonoscopy every 10 years appears to be sufficient.
- These screening tests can be effective in saving lives, but far too few people are using them.
- For example, just 40 percent of Americans over age 50 have ever had a fecal occult blood test or a sigmoidoscopy. This figure is far too low. Concern about more testing and unpleasantness of the test are big reasons why people do not get screened.
- NCI is collaborating with the CDC in *Screen for Life*, a nationwide campaign encouraging everyone over 50 to get screened.
- It is especially important that high-risk groups — anyone with ulcerative colitis, Crohn's disease, or with a strong family history of colorectal cancer and polyps — do not wait until age 50 to see their doctor and determine the age and regularity of screening. Genetic screening may be appropriate for

Additional Information on Colorectal Cancer Screening

Background

- Colorectal cancer (CRC) is the second leading cancer killer in the United States (after lung cancer), and the third most common non-skin cancer.
- In 2000, there will be an estimated 93,800 new cases of colon cancer and 36,400 new cases of rectum cancer [*Facts and Figures*, American Cancer Society, 2000]
- Incidence trends during the period 1990-1996 are downward or essentially flat for all race/ethnic groups. Blacks have consistently had the highest rate of new cases for both men and women at slightly over 51.5/100,000 and 42.5/100,000, respectively, in 1996. Whites have the next highest rates at 50.0 and 34.8/100,000, for men and women, respectively. Asian and Pacific Islanders have rates slightly lower than Whites for both genders and Hispanics and American Indians and Alaska Natives have the lowest rate of new cases. Data are from the National Cancer Institute's (NCI) Surveillance End Results (SEER) Program.
- In 2000 there will be 47,700 deaths from colon and 8,600 deaths from rectum [*Facts and Figures*, American Cancer Society, 2000]
- Trends in mortality for 1990-1996 have also been dropping for men and women. As with new cases, deaths from CRC are most common among Blacks at 26.9/100,000 for men and 19.5/100,000 for women in 1996. The lowest rates are among Hispanics, Asians and Pacific Islanders, and American Indians and Alaska Natives, who as a group have rates of from

12.3 to 13.8/100,000 for men and 7.7 to 9.6/100,000 for women. As with new cases, Whites have rates intermediate between Blacks and other race/ethnic groups.

- Eighty to 90 million Americans (approximately 25 percent of the US population) are considered at risk because of age or other factors. More women over the age of 75 die from colorectal cancer than from breast cancer.

Why Colorectal Cancer Screening (CRC) Makes Sense

Like cervical and prostate cancer, colorectal cancer has a relatively long preclinical phase (before symptoms appear) when the disease can be detected and cured. This makes colorectal cancer ideal for screening. Removal of precancerous polyps may be an effective way to prevent actual cancer. Polyps and early stage colon cancer do not usually cause symptoms. Colorectal cancer screening is like tuning up a car – you don't wait until the engine has died to go for a tune up; you go in before there are problems. It makes good sense to get screened before there are symptoms.

Three types of screening are widely available: fecal occult blood tests (FOBT), sigmoidoscopy and colonoscopy. The latter two can combine screening and treatment in one step by removing any polyps that are discovered. Another advantage is that they need to be performed infrequently, every five to ten years [Selby, 1992], while FOBT is recommended yearly.

Screening for Colorectal Cancer

National data about the proportion of the population that has been screened for colorectal cancer come from two main sources, the Behavioral Risk Factor Surveillance Survey (BRFSS, 2000) and the National Health Interview Survey (NHIS) (Healthy People 2000). The most recent data were collected respectively in 1997 and 1998. They did not ask about colonoscopy, a test that is widely used.

- Compared to women's participation in breast and cervical cancer screening and men's use of prostate cancer screening, rates for colorectal cancer screening are very low and haven't changed much over the last several years.
- According to the 1998 National Health Interview Survey, only 37% of adults over age 50 had a fecal occult blood test (FOBT) in the past 2 years. Rates were about the same for men and women. The rates were lower for Blacks; 30% said they had a FOBT in the past 2 years.
- About 35% of adults over age 50 say they have ever had a sigmoidoscopy; 31% of Blacks said they had ever had the test. Proportionately more men than women reported having had sigmoidoscopies; about 43% of men compared to about 33% of women. Since 1987, there has been about a 10 percentage point increase in the proportion of adults who have been screened for FOBT and an 8 percentage point increase for sigmoidoscopy—not nearly good enough if we are to reduce both new cases and deaths from colorectal cancer.

- Data from the 1997 BRFSS tell us more about age and ethnic differences in screening.
- Among people who reported having ever had an FOBT, Whites had slightly lower rates in the past year compared to Blacks and Hispanics--64% of Whites, 69% of Blacks and 68% of Hispanics.
- There were no major differences by gender or age for those over age 50. The situation is different for sigmoidoscopy. Among people who reported ever having had a sigmoidoscopy, 55% of men compared to 45% of women reported a sigmoidoscopy in the past 2 years. It is not known why the difference exists.
- Among people who reported ever having a sigmoidoscopy, Whites had the lowest rates within the past 2 years--48% of Whites, 61% of Blacks and 51% of Hispanics reported having had the test. Whites have the highest rates of ever having had the test; it appears that ethnic minorities are catching up, and this is good news.
- Sigmoidoscopy rates increase with age so that only 16% of adults 40-49 have ever had a sigmoidoscopy compared to 33% of adults 50-59, 43% of adults 60-64 and 47% of those 65+.
- Medicare data show that only 14% of Americans over age 65 had any of the four types of colon cancer screening in 1999 through Medicare (Associated Press, 2000).
- For screening to be effective in reducing morbidity and mortality from colorectal cancer, it must be done on a regular basis, i.e., in compliance with

recommended guidelines. However, the prevalence of repeat screening is low for both FOBT and sigmoidoscopy (Vernon, 1997).

Why Don't More People Get Screened for Colorectal Cancer?

- There are a number of reasons, including: not having symptoms, concern about further tests and unpleasantness of FOBT or the other tests (Hart et al., 1997); and being too busy (Vernon, 1997).
- As we have learned for breast cancer screening, cost is usually not the most important barrier to screening. Psychological and knowledge barriers and lack of a physician recommendation are more important.
- Nearly half (47%) the people surveyed in 1998 by the Gallup Organization for the National Colorectal Cancer Roundtable said that no medical professional had ever advised them to be screened (National Colorectal Cancer Roundtable, 1998).
- A new study of Medicare recipients identified the reasons many older people do not get screened (Associated Press, 2000). Some of them did not know Medicare would cover the tests; others said they would be too embarrassed to ask their doctors about screening or they were worried the tests would be uncomfortable.

Why Don't More Physicians Recommend Screening and Perform Screening for their Patients?

We don't have good national data on physician practices with regard to colorectal cancer screening. NCI is now conducting the first nationally representative survey of provider knowledge, attitudes and practices of CRC screening. 1,523 primary care and 1,404 specialty physicians are being surveyed. NCI is co-sponsoring these surveys with the CDC and HCFA. Preliminary data suggest that physicians' barriers to screening appear to be related more to patient and reimbursement issues than to a lack of capacity, in terms of facilities and providers, to provide screening.

An earlier survey in ten states indicated that primary physicians are more likely to recommend FOBT as the primary method of screening as opposed to sigmoidoscopy or other modalities. [Cooper et al., 1997). In this same survey there were several reasons that physicians did not screen patients for CRC.

- They were concerned that patients would not be willing to be tested.
- They were concerned about the time it takes to do sigmoidoscopies.
- They said they lacked the training to do them.
- They were worried about low reimbursement.
- They said they were concerned about the effectiveness of screening.

What Will It Take To Increase Screening?

We know from extensive research and practice, particularly from experience with breast cancer screening, much of it funded by NCI, that a successful early detection program must first understand, and then address, complex and interrelated multiple factors: physician knowledge, behavior and training, public

awareness, people's knowledge and psychological factors, financial and physical access, quality and follow up with abnormal test results, monitoring and evaluation.

- Research shows simple interventions such as reminder letters and calls to patients can dramatically increase the proportion of patients who get screened. About 50% of patients will respond to these simple prompts. It is surprising how few health care providers employ these intervention strategies today (Vernon, 1997).
- We've also learned that printed materials that are tailored to the needs of individuals can be very effective in increasing the proportion of people who get screened.
- The health care system also must include well-trained personnel and well-thought out systems that make it convenient for people to be screened.
- Physicians should not underestimate the power of their advice. If all physicians advised their patients 50+ to get colorectal cancer screening, we would see a dramatic increase in the proportion of patients who get screened. In addition, when physicians give people FOBT tests to do at home, they need to find out if patients have followed through. Physicians should encourage those who have not done the tests to do so.
- We need a better understanding of the specific barriers that keep people from being screened and physicians from recommending screening. NCI's researchers are prepared to do this research.

- We also need to develop effective interventions and diffuse them into the health care system, including the public health system. CDC has an important role in diffusing effective interventions through the public health system.

Cost Does Not Have To Be A Barrier

- Medicare now covers annual FOBT and sigmoidoscopy every four years. Colonoscopy every two years is covered for high-risk people. Many insurance plans and HMOs now pay for routine colorectal cancer screening for age or risk eligible persons. Some of the nation's HMOs, like Aetna/U.S. Healthcare and Kaiser Permanente, have led the way in encouraging their members to be screened.

National Efforts to Increase Colorectal Cancer Screening

- Public education efforts currently are underway to increase awareness about the benefits of colorectal cancer screening. Activities include the National Colorectal Cancer Roundtable, established by CDC and ACS with participation by the NCI, to strengthen the network of private and public organizations, to promote colorectal cancer screening. In March 1999, a national education campaign called "Screen for Life: National Colorectal Cancer Action Campaign" (www.cdc.gov/cancer/ScreenForLife) was launched to inform men and women aged 50 years and older about the importance of colorectal cancer screening for early detection and prevention. CDC is collaborating with the HCFA and NCI on this initiative. CDC and NCI are also

working with HCFA to promote Medicare's new coverage for colorectal cancer screening. In the United States, March has been established as "National Colorectal Cancer Awareness Month" to focus more attention and efforts toward the prevention and early detection of colorectal cancer.

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Prudence Squier
P.O. Box 10
Millwood, Va. 22646

February 4, 2000

The Honorable Bill Clinton
President of the United States
The White House
Washington, D.C.

Dear Mr. President:

My greatest pain in losing Bob is knowing that if he had been having regular medical check-ups someplace like the Mayo Clinic, where care is thorough and up-to-date, or if we had been better informed, we might have discovered his disease at an earlier, treatable stage.

Instead, we depended on a local, though respected physician, as most people in America do, assuming that he followed an acceptable schedule of state-of-the-art diagnostic procedures. Unfortunately, this was not the case. Bob's doctor had never ordered a routine colonoscopy for him despite his age and a history of cancer in his family. Doctors at Memorial Sloan-Kettering, where Bob received his cancer treatment, were appalled, and told his 39 year old son, Mark, to get a colonoscopy immediately. Mark got one, but his physician was against it. He said it wasn't necessary for him to do so for another 15 years, at age 55!

I polled our friends. Few had had a routine colonoscopy even though Memorial Sloan-Kettering recommends everyone have one every five years after age 50; people at high risk for cancer, even more often. Clearly, many doctors do not base their practices on the recommendations of the country's major medical centers when it comes to screening their patients for a variety of cancers. I also found a broad discrepancy among physicians regarding the age women should start having mammograms or being tested for cholesterol.

When I asked our physician why he had never ordered a routine colonoscopy for Bob he replied, "Insurance doesn't pay for it." Bob and I were willing to pay whatever was necessary to safeguard our health. I'm sure many others feel the same. People ought to know what tests are necessary to optimally protect their health, and it should be their decision how much to spend on these tests. Insurance company and HMO considerations should not confuse the issue.

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Domestic Policy Council
Devorah Adler
OA/Box Number: 20463

FOLDER TITLE:

Cancer Screening

2012-0463-S
rc725

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I believe lives could be saved in this country if a nationally recognized schedule for routine detection of cancer, heart disease and other major diseases were to be established so that:

1) Doctors uniformly would be aware of the standards that the country's major medical centers have established through their research.

2) Just as importantly, the public would be equally aware of these standards so they would know what to ask for when they have a routine check-up, and would know when to have one.

To make this happen I suggest that representatives of the country's major medical centers agree, with some latitude, on a standard for routine diagnostic testing for early detection of disease. If the White House backed this effort it would lend both credibility to the project and focus media attention on the conclusions of these medical professionals. If the Surgeon General and The National Institute of Health also approved their recommendations, further public awareness would be generated. I understand that the U.S.D.A. has approved guidelines for a healthy diet, which is taught in schools. It seems to me equally appropriate for the government to approve a standard schedule of diagnostic testing for routine medical check-ups.

You were very generous the other evening during our telephone conversation to ask me how you could help with this project. If you feel this is an effort the White House could organize and support I know that your personal involvement would guarantee it's success, and lives would be saved. Having lost Bob, I don't feel I can stand by and let others fall into the same trap we did. We were poorly informed ourselves and depended on a poorly informed physician to safeguard our health.

I have formed a committee of Bob's friends who are committed to working with me on this project. They are:

The Honorable Nancy H. Rubin P6/(b)(6) 0017
U.S. Ambassador, United Nations Commission on Human Rights

Miles Rubin

Barbara Cochran P6/(b)(6)
President, Radio and Television News Director Association

John Cochran
Senior White House Correspondent, ABC News

Wendy Walker Whitworth P6/(b)(6)
Executive Producer, Larry King Live/Senior Vice President, CNN

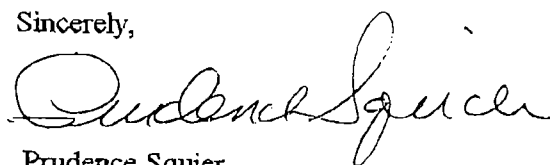
Kate Michelman
President, NARAL

P6/(b)(6)

I can be reached through my home phone at P6/(b)(6) but I plan to travel some with my sister in the next few weeks so it might be best to be in touch with one of the other committee members. I am free to work on this project any time.

Thank you so much for your kind and comforting words during this difficult time in my life. But most of all, thank you for your unfailing appreciation of Bob's talents and efforts on your behalf. He told me often how much this meant to him.

Sincerely,



Prudence Squier

c: Nancy Rubin
Miles Rubin
Barbara Cochran
John Cochran
Wendy Walker Whitworth
Kate Michelman

ACCOMPLISHMENTS ON COLORECTAL CANCER SCREENING

President's Proclamation of March as National Colorectal Cancer Awareness Month.

Continuation of the Screen for Life Campaign. In the second year of the Screen For Life Campaign, administered by the Centers for Disease Control, the National Institutes of Health, and the National Cancer Institute (NCI), will invest \$2.5 million to produce two televised public service announcements encouraging all Americans over the age of 50 to be screened for colorectal cancer that will be distributed to over 130 of the 200 major media markets beginning on June 1. New patient education fact sheets, posters, and brochures will also be distributed to physicians through the American Cancer Society and other Screen for Life partners at that time. The Screen For Life Campaign was launched in 1998 by First Lady Hillary Rodham Clinton.

New Efforts to Educate the Public About the Importance of Screening. The Health Care Financing Administration (HCFA) will release a Video News Release on the importance of colorectal cancer screening to 800 local media markets nationwide by early June. These "news vignettes", which will highlight who is at enhanced risk for colorectal cancer, the effectiveness of early detection, and the fact that Medicare covers the screening tests, run approximately two to three minutes and are used as filler during the evening news segments. A recent study released by GAO indicates that only 30 percent of Medicare beneficiaries are being appropriately screened for colorectal cancer.

New Provider Education Efforts. On March 20 and March 23, HCFA will convene a meeting with State Medical Association representatives nationwide to educate them about the preventive services covered by the Medicare program. A segment of this conference call, which will be down-linked by satellite to Medicare providers, will focus on the importance of colorectal cancer screening for older Americans and review the NCI guidelines for screening. HCFA will also add a special segment on provider webpage on colorectal cancer screening in early June. A survey of providers in 10 states indicate that there are a number of provider misconceptions that prevent primary care physicians from appropriately screening patients for colorectal cancer, including concerns about low reimbursement rates; the effectiveness of screening; and patient willingness to be tested.

New Research on Physician Practices. NCI is currently conducting the first nationally representative survey of provider knowledge, attitudes, and practices on colorectal cancer screening, consulting with almost 3,000 providers nationwide. This study, which began last year, will be used to inform provider and patient education efforts in order to develop a set of best practices for colorectal cancer screening nationwide when completed.

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Colorectal Cancer Prevention and Control Initiatives

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About the Program

You may also download a [PDF version \(156K\)](#) for [Adobe Acrobat Reader](#) or a [PostScript version \(448K\)](#).

Colorectal Cancer: The Importance of Early Detection

AT-A-GLANCE
1999



"We now have clearer insight into the natural history of colorectal cancer, better understanding of its biologic features, and clinical skills with which to intervene and make a difference for many people. Colorectal cancer screening has come of age."

Sidney J. Winawer, MD, Memorial Sloan-Kettering Cancer Center, New York

Reprinted by permission of The New England Journal of Medicine,
Massachusetts Medical Society

Colorectal Cancer

How Common Is Colorectal Cancer?

Colorectal cancer — or cancer of the colon or rectum — is the second leading cause of cancer-related death in the United States. The American Cancer Society estimates that 56,600 Americans will die of colorectal cancer in 1999.

When skin cancer is excluded, colorectal cancer is the third most commonly diagnosed cancer for both men and women in the United States. Approximately 129,400 new cases will be diagnosed during 1999. For men, colorectal cancer follows prostate and lung cancers in frequency; for women, it follows breast and lung cancers.

Who Is at Risk?

The risk of developing colorectal cancer generally increases with advancing age. African Americans are more likely than whites to be diagnosed with this disease and are more likely to die of it.

Other major risk factors include having inflammatory bowel disease, a family history of colorectal cancer or colorectal polyps, and certain hereditary syndromes. Additional conditions contributing to increased risk for colorectal cancer include a personal history of colorectal cancer or polyps or of ovarian, endometrial, or breast cancers. Lack of regular physical activity can contribute to increasing one's risk; low fruit and vegetable intake, a low-fiber and high-fat diet, obesity, and alcohol consumption are other possible risk factors.

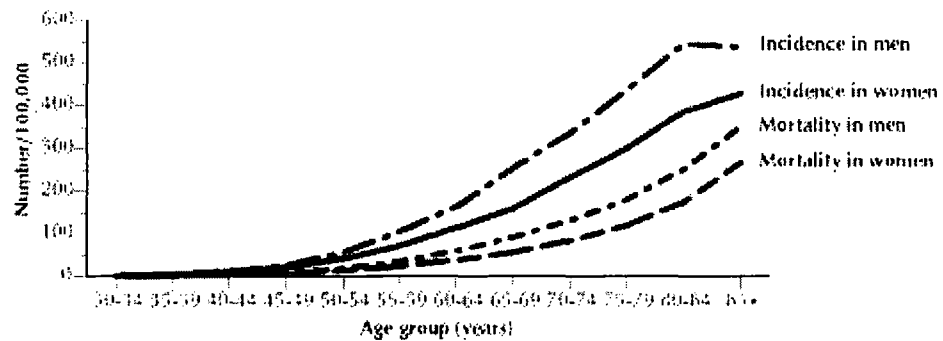
Early Detection---A Key to Survival

Survival is greatly enhanced when colorectal cancer is detected early and appropriate treatment provided. Despite the availability of effective screening tests, colorectal cancer screening is underused. Studies show that only 37% of colorectal cancers are diagnosed at a localized stage.

When colorectal cancer is diagnosed at a localized stage, death rates are low: only about 9% of these patients will die within 5 years. Once the disease has progressed to a regional stage, about 34% of patients will die within 5 years. When the disease is diagnosed at an advanced stage (has spread to distant sites), death rates are high: about 92% of patients will die within 5 years. For African Americans, 5-year survival rates are lower than those for whites, and a smaller proportion of cases are diagnosed at an early stage.

Precancerous polyps may be present in the colon for years before invasive cancer develops. Colorectal cancer can actually be prevented by removing precancerous polyps. Reducing the number of deaths from colorectal cancer depends on detecting and removing precancerous colorectal polyps, as well as detecting and treating cancer in its earliest stages.

Cancers of the Colon and Rectum: Incidence and Mortality Rates, by Sex, United States, 1990–1995 *



*Average annual age-specific data.

Source: National Cancer Institute, *SEER Cancer Statistics Review, 1973–1995*

Types of Screening

Two currently available tests have been shown to be beneficial in screening for colorectal cancer:

- **The fecal occult blood test (FOBT)** is a chemical test for blood in a stool sample. A study conducted in the United States showed a 33% reduction in colorectal cancer deaths among the participants who were annually screened by FOBT.
- **Flexible sigmoidoscopy** can detect about 65%–75% of polyps and 40%–65% of colorectal cancers. In this screening procedure, a hollow, lighted tube is used to visually inspect the wall of the rectum and the left side of the colon.

Three other tests for colorectal cancer are commonly used in clinical practice, although no direct evidence as yet supports their efficacy in reducing illness and death. Two of these tests, colonoscopy and double contrast barium enema (DCBE), are used to examine the interior wall of the entire colon. They are also used as follow-up diagnostic tools when the results of another screening test are positive. A third common procedure, digital rectal examination, can inspect only a limited area.

Guidelines for Screening

Underuse of Screening

Currently, screening for colorectal cancer lags far behind screening for other cancers, perhaps because the effectiveness of colorectal cancer screening has only recently been documented. Findings from CDC's state based Behavioral Risk Factor Surveillance System indicated that in 1997, only 41% of adults

aged 50 and older had ever had a sigmoidoscopy or proctoscopy (an earlier and now less frequently used procedure) for screening or diagnostic purposes, and only 29% of respondents reported having had one within the past 5 years. Of the survey respondents, 39% of adults aged 50 and older reported ever having an FOBT using a home kit, and only 19% reported having this test in the preceding year.

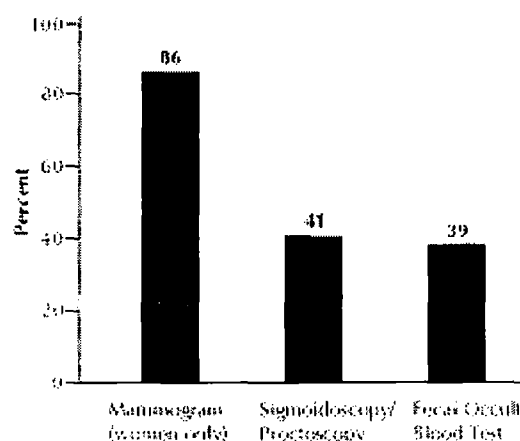
Current Guidelines

Acting on recent evidence that screening, along with appropriate follow up and treatment, reduces deaths from colorectal cancer, several scientific organizations recommend regular screening of all average-risk adults aged 50 and older. Recommended screening procedures include the following:

- Annual FOBT.
- Flexible sigmoidoscopy every 5 years.
- Total colon examination by colonoscopy every 10 years or by DCBE every 5–10 years.

Those at higher risk should be offered more intensive surveillance. The U.S. Preventive Services Task Force, the American Cancer Society, and the Interdisciplinary Task Force (originally convened by the federal Agency for Health Care Policy and Research and supported by five major gastroenter-ological societies) have developed detailed guidelines related to colorectal cancer screening. These guidelines all emphasize the key health benefit of colorectal cancer screening—finding and removing precancerous polyps and cancer, thus either preventing the development of cancer or detecting this disease at an early, more treatable stage.

Prevalence of Ever Having a Particular Cancer Screening Test—U.S. Adults Aged 50 and Older



Source: CDC, Behavioral Risk Factor Surveillance System, 1997.

2.86 million
FY2000

CDC Program Activities

With approximately \$2.5 million available in fiscal year 1999 to target colorectal cancer, CDC is promoting colorectal cancer screening nationwide by educating health care providers and the public about the benefits of screening, the availability of screening procedures, and current screening guidelines. CDC also supports investigations to determine clinical and consumer barriers to screening. For example,

- The National Colorectal Cancer Roundtable, established by CDC and the American Cancer Society, is strengthening the network of public and private organizations promoting colorectal cancer screening among all people for whom screening is appropriate. Partners include state health departments, professional organizations (such as the American Digestive Health Foundation and the Digestive Disease National Coalition), medical societies, federal agencies, consumers, cancer survivors, managed care organizations, private industry, health educators, and the medical media.
- In September 1998, the Roundtable participated in a special White House event featuring First Lady Hillary Rodham Clinton, NBC Today show co-anchor Katie Couric, and Good Housekeeping Editor-in-Chief Ellen Levine to promote colon cancer prevention and early detection. As part of the event, public service announcements were released to raise public awareness about the benefits of colorectal cancer screening. Good Housekeeping plans to continue its emphasis on this important public health concern during 1999.
- CDC is working with the Health Care Financing Administration to promote Medicare's new coverage for colorectal cancer screening. This effort is part of CDC's larger communication initiative to promote colorectal cancer screening among Americans aged 50 and older. CDC is planning a multiyear, targeted public education campaign to promote colorectal cancer screening; the campaign is tentatively scheduled to begin in winter 1998-1999.
- CDC has provided national leadership in bringing together state health department personnel and other key partners to identify opportunities and develop strategies for colorectal cancer initiatives. During 1999, CDC will support six states and tribal organizations to begin implementing comprehensive cancer control programs, which will include efforts targeting colorectal cancer.

In addition, CDC

- Supports the Agency for Health Care Policy and Research, the Harvard School of Public Health, and the RAND Corporation in developing and evaluating a colorectal

cancer screening measure for potential inclusion in the Health Plan Employer Data and Information Set (HEDIS), a system of quality monitoring for national managed care plans.

- Supports studies with the Kaiser Permanente Medical Care Program of Northern California and the Imperial Cancer Research Fund in Great Britain to determine factors associated with patients' interest and participation in sigmoidoscopy screening.
- Works with the Alliance of Community Health Plans (ACHP) to validate self-reported history of colorectal cancer screening by comparing responses from a telephone survey to information recorded on medical charts for a sample of adults aged 50 and older.
- Works with the ACHP and the Kaiser Permanente Medical Care Program of Northern California to study potential complications associated with sigmoidoscopy.
- Provides support to the Center for Health Promotion and Disease Prevention at the University of North Carolina at Chapel Hill to develop standards for performing and reporting results of sigmoidoscopies.
- Works with the American Cancer Society and the National Cancer Institute to conduct a national survey of primary care physicians to determine their knowledge and attitudes about colorectal cancer screening and their perceptions of screening barriers.

For more information, please contact the Centers for Disease Control and Prevention,
National Center for Chronic Disease Prevention and Health Promotion,
Mail Stop K-64, 4770 Buford Highway NE, Atlanta, GA
30341-3717, (770) 488-4751, Fax: (770) 488-4760.

Voice Information System: 1 (888)842-6355

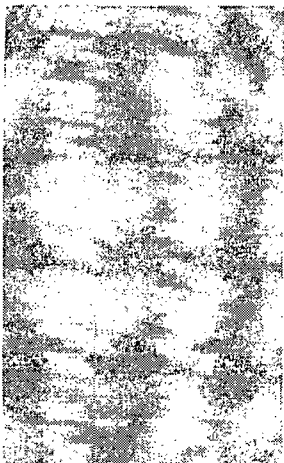
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HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Tuesday, March 2, 1999

Contact: Kathy Harben
(770) 488-5131 CDC Press
Office
(404) 639-3286

National Colorectal Cancer Campaign Announced by CDC, HCFA and NCI

"Screen for Life" launched in response to new data revealing that too few Americans use colorectal cancer screening for early detection and prevention

A national campaign to educate Americans 50 and older about colorectal cancer - the nation's number two cancer killer - was launched today by the Centers for Disease Control and Prevention (CDC), Health Care Financing Administration (HCFA), and National Cancer Institute (NCI). The Screen for Life campaign informs Americans 50 and older, the age group most at risk for colorectal cancer, about the importance of colorectal cancer screening tests for early detection and prevention of the disease.

The campaign was launched as new evidence was published in the Journal of the National Cancer Institute showing significant reduction in colorectal cancer deaths associated with regular screening.

"The good news is that we can prevent many deaths from colorectal cancer through screening," said Surgeon General David Satcher. "If you've celebrated your 50th birthday and have never been screened for colorectal cancer, start now to screen for life."

Colorectal cancer, or cancer of the colon or rectum, is second only to lung cancer as a cause of cancer-related death in the United States. An estimated 129,400 men and women will be diagnosed with colorectal cancer in 1999, and more than 56,000 lives will be lost to this disease. Many colorectal cancer deaths could be prevented with screening.

Most Americans 50 and older, however, do not get screening tests for colorectal cancer. CDC recently released data showing that only 41 percent of men and women of that age are having either of the two most commonly recommended screening tests, home-administered blood stool tests or sigmoidoscopy/proctoscopy (physician examinations of the rectum and lower colon), within the recommended time intervals.

As proposed by President Clinton, new Medicare preventive benefits including colorectal cancer screening were enacted in 1997 and went into effect last year. Today's campaign is aimed at encouraging Medicare beneficiaries and others to take advantage of screening to reduce colorectal cancer in the United States.

"Medicare took a big step forward in covering preventive benefits," Nancy-Ann DeParle, HCFA administrator said. "Now, through Screen for Life, we're able to promote healthy aging and help beneficiaries take an active role in their health."

The Screen for Life campaign includes public service announcements and information materials targeting Americans 50 and older. The campaign also will promote the new Medicare coverage of colorectal cancer screening procedures.

Most colorectal cancers begin first as small growths, called polyps, inside the colon or rectum. Screening

can detect these growths; removing them can prevent cancer.

In the Journal article released today, researchers at the University of Minnesota reported on an 18-year study which extends their findings that screening for blood in the stool can reduce mortality from colorectal cancer. The team, led by Jack Mandel, Ph.D., professor of public health, found that annual screening with a simple and inexpensive fecal occult blood test can lead to a 33 percent reduction in mortality, and that biennial screening (every two years) results in a 21 percent drop in mortality.

CDC and other health organizations, including the American Cancer Society and gastroenterologic organizations, support the blood stool test or a combination of several tests for colorectal cancer screening.

CDC, the nation's disease prevention agency within the Department of Health and Human Services, is responsible for promoting health and quality of life by preventing and controlling disease, injury, and disability. CDC's efforts in colorectal cancer prevention education have included funding for innovative strategies at the state and national levels, development of epidemiological research and surveillance systems for monitoring national trends, and coordination of a national roundtable to prevent colorectal cancer.

For more information, visit the Screen for Life web site: www.cdc.gov/cancer/screenforlife. Also learn more about colorectal cancer screening by calling NCI's Cancer Information Service at 1-800-4-CANCER; to order Screen for Life campaign materials, call 1-888-842-6355. For more information about Medicare benefits, visit www.medicare.gov.

#

Note: U.S. Surgeon General David Satcher will be available for interviews 1-2 p.m. EST on March 2, 1999. Contact Kathy Harben at (770) 488-5131 to arrange for interviews. In addition, satellite feed of Surgeon General interview, plus B-roll, will be available at 11 a.m. and 2 p.m. EST. Satellite coordinates are: 11:00 a.m.-11:30 a.m. (EST) Galaxy 6 (C-band)/Transponder 5, 6.2/6.8 audio (standard) and 2:30 p.m.-3:00 p.m. (EST) Galaxy 6 (C-band)/Transponder 12, 6.2/6.8 audio (standard).

Note: HHS press releases are available on the World Wide Web at: <http://www.hhs.gov>.

1998 Medicare Preventive Service Benefits Colorectal Cancer Screening

Effective 1/1/98

Description of Coverage	Co-pay/Deductible
• Screening fecal occult blood test (FOBT) – 1 every 12 months for Medicare beneficiaries who are 50 and older. • Screening flexible sigmoidoscopy – 1 every 48 months for Medicare beneficiaries who are 50 and older. • Screening colonoscopy – 1 every 24 months for Medicare beneficiaries at high risk for colorectal cancer. • Screening barium enema may be substituted for either a screening flexible sigmoidoscopy or a screening colonoscopy at the attending physician's discretion, but payment may not be made for both a screening barium enema and either of these other procedures.	• FOBT: No co-pay and no Part B deductible. • Other tests: Subject to Part B deductible and 20 percent co-pay.

CPT Codes

- FOBT – G0107
- Flexible sigmoidoscopy – G0104
- Colonoscopy – G0105
- Barium enema instead of sigmoidoscopy – G0106
- Barium enema instead of colonoscopy – G0120

Source: Health Care Financing Administration, December 10, 1997.

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health policy speaker.

Dave Bernell

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Melanie

Karen

Maria

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Testimony

Before the Special Committee on Aging,
U.S. Senate

For Release on Delivery
Expected at 1:00 p.m.
Monday, Mar. 6, 2000

MEDICARE

Few Beneficiaries Use
Colorectal Cancer
Screening and Diagnostic
Services

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health and Human Services Division



Medicare: Few Beneficiaries Use Colorectal Cancer Screening and Diagnostic Services

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the use of Medicare-covered screening and diagnostic services to prevent colorectal cancer and minimize its effect on beneficiaries' health status through early detection and treatment. Colorectal cancer is the second leading cause of cancer death in the United States. Currently, only about a third of all colorectal cancers are diagnosed at an early stage. Widespread screening aims to detect the disease early, and in many cases, the detection and removal of precancerous growths may actually prevent colorectal cancer. The Balanced Budget Act of 1997 expanded Medicare coverage to include colorectal cancer screening services. The Congress' decision to include colorectal cancer screening as a Medicare benefit reflected an awareness that early screening and detection are important to maintaining beneficiaries' health.

At your request, we examined the extent to which this new preventive health service has been used since its addition to the Medicare benefit package. Accordingly, my remarks will focus on (1) the extent to which Medicare beneficiaries (both aged and disabled) are using colorectal cancer screening and diagnostic services and (2) efforts to address barriers identified as limiting use. To do this analysis, we determined patient use rates from Medicare claims data from 1995 through June 1999.¹ We could not measure use rates for screening services alone because of coding and other technical issues.² In addition, we reviewed recent literature and obtained information from medical specialty organizations, patient advocacy groups, agencies in the Department of Health and Human Services (HHS), and several health maintenance organizations (HMO) with Medicare contracts.

In brief, we found that the use of colorectal cancer screening and diagnostic services by Medicare beneficiaries is very low relative to recommended use rates and has remained almost unchanged over the past 5 years. Although guidelines recommend annual fecal occult blood testing

¹We used physician claims from Medicare's 5 percent Standard Analytic File, which contains all claims for a 5 percent sample of Medicare Part B beneficiaries.

²We included diagnostic and treatment codes in developing our use rates because it is likely that at least some services coded as diagnostic are for screening. In fact, one study has estimated that approximately 44 percent of beneficiaries who had a diagnostic fecal occult blood test in 1995 could be identified as lacking clinical evidence of a digestive system disease or general symptoms and therefore represented a screening population. In addition, physicians might not have used the new screening codes consistently on their 1998 and 1999 claims for colorectal cancer screening since the amount reimbursed for the new screening services was the same as that for diagnostic services. Furthermore, colonoscopies begun as a screening procedure are coded as treatment procedures under certain circumstances, such as if a polyp is removed.

for all people aged 50 and older, only 9 percent of fee-for-service beneficiaries received that test each year. Use rates for flexible sigmoidoscopy are significantly lower and have also remained constant at about 2 percent of beneficiaries. Women's use of some colorectal cancer screening and diagnostic services was slightly higher than men's, and white beneficiaries received the services at somewhat higher rates than African Americans, Asians, and Hispanics. Although use data are not available for Medicare beneficiaries in HMOs, research suggests that enrollees in managed care plans are at least as likely to have colorectal cancer screening as those in fee-for-service Medicare. Various factors contribute to the low use of screening and diagnostic services, some of which are beginning to be addressed by public health agencies and private organizations. Key among these is poor patient awareness of recommendations and coverage for screening, physician reluctance to perform the procedures because of the time and complexity involved, and lack of monitoring systems to encourage greater use.

Background

Colorectal cancer is the third most commonly diagnosed cancer for both men and women in the United States. An estimated 129,400 new cases and 56,600 deaths from colorectal cancer were expected in 1999. Among the general population, the colorectal cancer mortality rate in 1997 was 21.6 per 100,000 individuals. Broken down into demographic groups, the mortality rate for African Americans was twice that for Hispanic, Asian, or Native Americans, and for men it was more than 40 percent greater than that for women.³ According to medical experts, the risk factors for colorectal cancer include older age, family history, certain hereditary conditions, a diet high in saturated fat and low in fiber, excessive alcohol, and sedentary life style.

Research shows that the number of people developing and dying of colorectal cancer could be reduced through screening (identifying people with precursors to or early signs of the disease) and surveillance (monitoring people with previously diagnosed colorectal disease). Studies have shown that in the majority of colorectal cancers, noncancerous polyps grow slowly for 10 years or longer in the colon in a benign state before becoming cancerous. Identification and removal of the polyps during that time can prevent colorectal cancer from developing. In 1997, a consortium led by the American Gastroenterological Association produced clinical practice guidelines to address uncertainty about the choice and

³Mortality rates per 100,000 in 1997 were 28.8 for blacks, 21.1 for whites, 14.5 for Native Americans, 13.5 for Asians, 12.8 for Hispanics, 26.0 for men, and 18.4 for women. See HHS, Healthy People 2010 (Washington, D.C.: 2000).

frequency of screening tests for different groups of patients.⁴ For people at average risk of developing colorectal cancer, the practice guidelines recommend that people aged 50 and older have a fecal occult blood test annually, a flexible sigmoidoscopy every 5 years, an optional double-contrast barium enema every 5 to 10 years, and a colonoscopy every 10 years. For groups at high risk, experts recommend more frequent screening through colonoscopy.

The Medicare benefit for colorectal cancer screening addresses several of the clinical practice recommendations. Before January 1, 1998, Medicare covered the fecal occult blood test, sigmoidoscopy, colonoscopy, and barium enema only for diagnosis and treatment, such as for evaluating a specific complaint or monitoring an existing medical condition. The Balanced Budget Act of 1997 extended coverage of these services for screening purposes, with no coinsurance and deductible for the fecal occult blood test. For all other tests, the cost sharing is the same as for treatment services, which is payment of 20 percent of the Medicare approved amount after the yearly deductible.⁵ For people at average risk for colorectal cancer (those with no predisposing factors), Medicare now pays for a screening fecal occult blood test every year and a screening sigmoidoscopy every 4 years for beneficiaries aged 50 and older. In addition, for individuals at high risk, Medicare covers a screening colonoscopy every 2 years.⁶ For both risk groups, a double-contrast barium enema may be substituted at the same frequency as the sigmoidoscopy or the colonoscopy, if the physician believes that it is appropriate.

⁴These guidelines were based on work initially funded by the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality, or AHRQ). After the agency discontinued its guideline program in May 1996, the project was completed with funding from several professional associations in fields related to gastroenterology. The American Cancer Society, the Crohn's and Colitis Foundation of America, and a number of other organizations have endorsed the guidelines.

⁵The President's proposed budget for fiscal year 2001 calls for eliminating copayments and deductibles for these services to further facilitate patient's access to care.

⁶There is no minimum age for a screening colonoscopy for high-risk beneficiaries.

Few Beneficiaries Have Colorectal Cancer Screening or Use Diagnostic Services

Overall use of colorectal cancer screening and diagnostic services among Medicare beneficiaries is generally low. Despite the issuance of the clinical practice guidelines in 1997 and the expanded Medicare benefit that became effective in 1998, use has not changed significantly since 1995. Use rates for these services varied slightly among demographic groups and across states. Studies show that the use of colorectal cancer screening services in managed care health plans is the same as or higher than in fee-for-service arrangements.

Overall Use of Colorectal Cancer Screening and Diagnostic Services Remains Low

Despite the fact that nearly all older Americans report having a regular source of health care and a large majority report receiving routine checkups, Medicare beneficiaries' use of colorectal cancer services falls far short of recommended levels. In 1999, 14.1 percent of beneficiaries had one or more of the covered services (fecal occult blood test, flexible sigmoidoscopy, colonoscopy, or double-contrast barium enema) for screening or diagnostic purposes.⁷ Overall use is roughly equivalent to rates in 1995, when 13.6 percent of beneficiaries used any of these services.

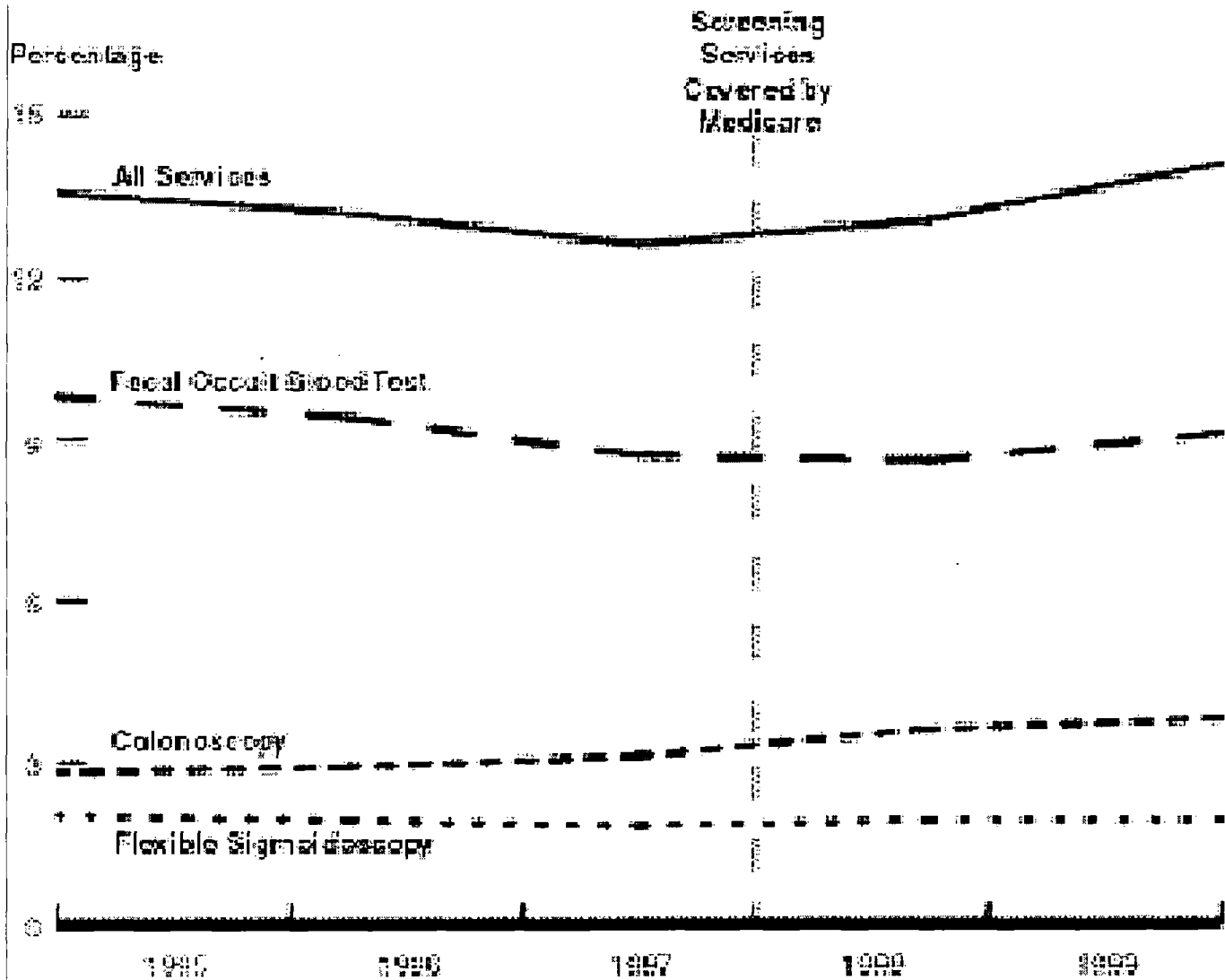
Among the colorectal cancer screening and diagnostic services, the most common and least invasive is the fecal occult blood test. In 1999, the use rate for this service was 9.1 percent of beneficiaries, well below the recommended rate of once a year.⁸ In the same year, the use rate for flexible sigmoidoscopy, which is covered every 4 years, was 1.9 percent, while 3.8 percent of beneficiaries received a colonoscopy.⁹ Figure 1 shows use rates for these services over the past 5 years.

⁷We estimated 1999 use rates from claims paid between January and June 1999. The overall use rates include treatment colonoscopies because such procedures may have been initiated for screening purposes. Although screening colonoscopy is covered only for beneficiaries at high risk for colorectal cancer, diagnostic and treatment colonoscopy is covered for all beneficiaries.

⁸This may be an undercount of actual use. Because fecal occult blood testing is inexpensive (payments average less than \$4.00 per service), it may be performed more often than it is billed to Medicare.

⁹We did not separately identify rates for double-contrast barium enema because use was extremely low.

Figure 1: Little Change in Medicare Beneficiaries' Use Rates for Colorectal Cancer Screening and Diagnostic Services, 1995-99



Source: GAO analysis of Health Care Financing Administration claims data.

Similar data are not available on the use of colorectal cancer services by enrollees in the Medicare managed care program, called Medicare+Choice, because the Health Care Financing Administration (HCFA) does not require Medicare+Choice plans to report patient-specific data. However, evidence suggests that colorectal cancer screening rates among Medicare HMO beneficiaries may be similar to or higher than use rates among fee-for-service beneficiaries. In a recent synthesis of studies on the use of preventive care, researchers found that enrollees in managed care plans were at least as likely as those in other plans to obtain colorectal cancer screening services.¹⁰ One-third of comparisons of colorectal cancer screening use found that managed care enrollees were more likely to use the services and two-thirds of comparisons found no difference in use between enrollees in managed care plans and nonmanaged care plans. Enrollees in group and staff model HMOs—which accounted for 4.4 percent of Medicare beneficiaries in 1998—were significantly more likely than those in fee-for-service Medicare or other types of HMOs to obtain preventive services in general.

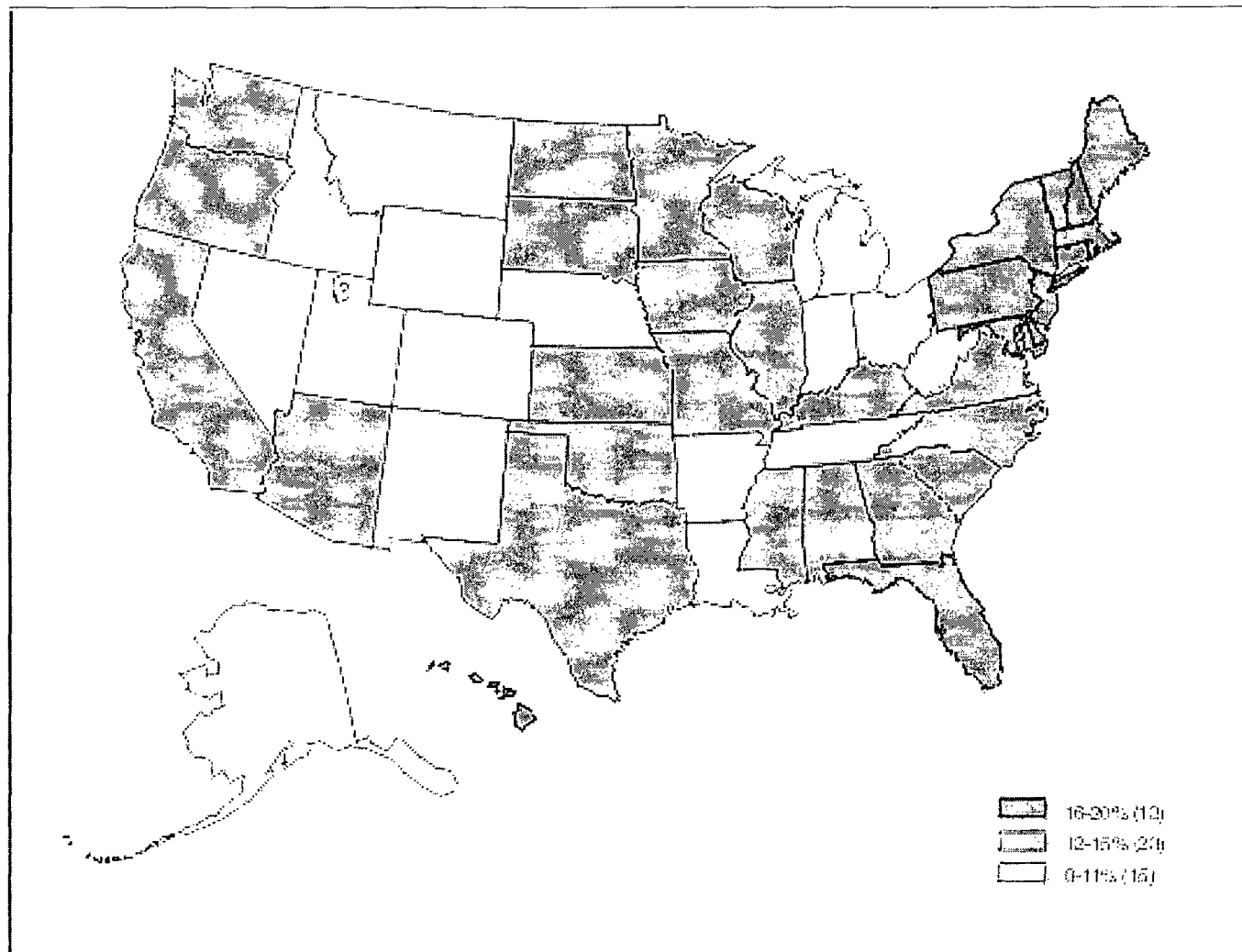
The Use of Screening and Diagnostic Services Varied Slightly Among Demographic Groups and States

Analyzing use rates by patients' demographic characteristics, we found that use varied only slightly by age, race, gender, and geography. These rates also remained relatively constant over the 5-year study period. (See appendix for a breakout of demographic and geographic differences in use rates.) Specifically,

- Women had higher use rates in 1999 for fecal occult blood test (about 10 percent, compared with 8 percent for men) and similar rates for flexible sigmoidoscopy and colonoscopy.
- Beneficiaries aged 70 to 79 were most likely to use screening and diagnostic services, but their use rates were only about 13 percent higher than for those aged 65 to 69 or 80 to 84.
- White beneficiaries received the screening and diagnostic services at consistently higher rates (about 15 percent in 1999) than Asians (about 13 percent), African Americans (approximately 9 percent), or Hispanics (approximately 8 percent).
- In general, a higher percentage of beneficiaries in Massachusetts and Rhode Island (18 to 20 percent) received screening and diagnostic services consistently over the 5-year period than beneficiaries in other states. (See figure 2 for more information about use rates across states.)

¹⁰Kathryn A. Phillips and others, "Use of Preventive Services by Managed Care Enrollees: An Updated Perspective," *Health Affairs*, vol. 19, no. 1 (Jan.-Feb. 2000), pp. 102-16.

Figure 2: States Varied in Use Rates for Colorectal Cancer Services, 1999



Source: GAO Analysis of Health Care Financing Administration claims data.

Efforts To Overcome Barriers To Colorectal Cancer Screening

Many factors affect the use of colorectal cancer screening services, including patient, physician, and delivery system issues. Some patients find the procedures overly invasive, and others, including some physicians, may be unaware that an effective preventive opportunity exists and that Medicare provides coverage. In addition, the lack of attention to colorectal cancer screening compared with other preventive services may

so be a reason for its low use. Federal agencies, medical societies, and patient groups are undertaking a variety of initiatives to improve the use of colorectal cancer screening.

Patient Barriers

Researchers have identified a lack of patient awareness, understanding, and inclination as the most significant factor inhibiting the use of colorectal cancer screening services. In a 1997 report, the Agency for Healthcare Research and Quality (AHRQ) found a very low level of awareness about the risks of colorectal cancer and its symptoms among adults. It also found that people are more likely to participate in screening when they understand the nature of the disease and feel they are at risk for it. Good communication between health care providers and patients and the effective use of educational materials could enhance patient participation in screening, AHRQ researchers concluded.

Although information for patients is essential, it may not be enough.¹¹ In 1998, the Centers for Disease Control and Prevention (CDC), in partnership with HCFA, conducted 14 focus groups with adults aged 50 and older to examine the factors that inhibit appropriate use of colorectal cancer screening. Consistent with AHRQ's 1997 study, CDC found that the participants were not aware that colorectal cancer is the third most prevalent cancer, nor were they aware of the benefits of screening and early detection. However, the focus groups also revealed that older adults, particularly those older than 65, are unwilling to discuss issues of colorectal cancer screening, even with their physicians.¹² Representatives of several physician and patient groups echoed these results, telling us that many people find colorectal cancer screening tests inconvenient or embarrassing or that they may be concerned about potential discomfort during the screening.

Because Medicare now covers colorectal cancer screening services, HCFA is taking steps to promote beneficiary awareness of the new benefit, as are other agencies within HHS. For example,

¹¹A recent study of elderly patients visiting their primary care providers for routine office visits examined the effect of information on preferences for colorectal cancer screening. It found that a large proportion preferred not to be screened and concluded that factors other than information determine screening decisions. See A. M. Wolf and J. B. Schorling, "Does Informed Consent Alter Elderly Patients' Preferences for Colorectal Cancer Screening? Results of a Randomized Trial," *Journal of General Internal Medicine*, vol. 15, no. 1 (Jan. 2000), pp. 24-30.

¹²CDC expected to find a certain level of reluctance regarding sigmoidoscopy, colonoscopy, and barium enema, which are involved screening tests that require significant preparation and, in some cases, a hospital (usually outpatient) visit. They were surprised to find resistance to the fecal occult blood test, which patients reported as unpleasant, confusing, and frustrating.

- HCFA's Medicare and You handbook, which was mailed last year to all beneficiaries, describes the colorectal cancer screening benefit along with other covered preventive services. In addition, HCFA has distributed pamphlets regarding colorectal cancer screening to beneficiary groups, posters for senior citizen centers, and television and radio public service announcements, some of which target women and African Americans.
- Along with the American Cancer Society, CDC has established the National Colorectal Cancer Roundtable to bring together state health departments, professional medical societies, and other public and private organizations to promote colorectal cancer screening among medical providers and the public. The roundtable seeks to determine clinical and consumer barriers to screening, assess current public awareness of and interest in screening, and develop and disseminate promotional messages.
- In collaboration with HCFA and the National Cancer Institute (NCI), CDC has launched a public awareness campaign, "Screen for Life," to promote colorectal cancer screening that includes public service announcements and brochures in both English and Spanish, press kits, and a Web site on colorectal cancer (www.cdc.gov/cancer/screenforlife). CDC has also supported studies regarding participation in screening.

In addition, some health plans that participate in Medicare+Choice have set up programs to encourage the appropriate use of screening services. While these activities do not represent those of the managed care industry overall, they illustrate a variety of approaches to improving patients' use of colorectal cancer screening tools. For example:

- Kaiser Permanente in Northern California has screened more than 300,000 members older than 50 with sigmoidoscopy and has reported a one-third reduction in advanced colorectal cancer cases among the targeted population.
- Group Health Cooperative in Puget Sound has used mailings to members to provide information about the importance of regular screening and to improve familiarity with the screening procedures.
- Aetna U.S. Healthcare mails a fecal occult blood test kit to members aged 50 and older, along with instructions for completing the test, and educational materials about colorectal cancer. The plan's Prudential Center for Health Care Research is conducting a study to determine the rate of colorectal cancer screening among plan members older than 50, assess barriers to screening, and improve screening rates.

Physician Barriers

Physicians practices, too, can affect rates of colorectal cancer screening. In a 1999 report, CDC stated that physicians may lack skills (such as training in prevention) or time to counsel patients, or they may be unfamiliar with updated colorectal cancer screening guidelines (which now have broad-based support).¹³ A study of primary care physicians in a large health care system found that half of those trained in flexible sigmoidoscopy chose not to perform this procedure. The reasons most often given were the time required for the procedure, the availability of adequately trained staff, and the availability of flexible sigmoidoscopy services from other clinicians.¹⁴ One study has also attributed the reluctance of primary care physicians to provide this screening to their impression that reimbursement rates are inadequate to cover their costs.¹⁵

Federal agencies, physicians' groups, and others have special programs to address the lack of widespread physician use of these services. For example,

- To obtain nationally representative data on barriers to colorectal cancer screening and early intervention, NCI is supporting a survey of primary and specialty care physicians and health plan medical directors that will assess physicians' knowledge, attitudes, and practice patterns.
- Both the American Association of Family Physicians (AAFP) and the American College of Physicians have guidelines for their members. In addition, AAFP distributed information to its members about the new Medicare coverage for these services and the importance of screening patients.
- A program developed by a large academic medical center in Louisiana has an arrangement with local primary care physicians that allows patients to be referred to the clinic one morning every week, without appointments, for screening flexible sigmoidoscopies.

Health System Barriers

Colorectal cancer screening may also be limited by insufficient attention to prevention, in general, and a lack of systems to track and monitor the provision of screening services. The Healthy People 2010 report noted that measuring and reporting how well preventive care is provided are

¹³CDC, Morbidity and Mortality Weekly Report, vol. 48, no. 6 (Feb. 19, 1999), pp. 116-21.

¹⁴J. D. Lewis and others, "Primary Care Physicians' Decisions to Perform Flexible Sigmoidoscopy," *Journal of General Internal Medicine*, vol. 14, no. 5 (May 1999), pp. 297-302.

¹⁵See J. D. Lewis and D. A. Asch, "Barriers to Office-Based Screening Sigmoidoscopy: Does Reimbursement Cover Costs?" *Annals of Internal Medicine*, vol. 130, no. 6 (Mar. 1999), pp. 525-30.

essential to greater compliance with recommendations. It recognized that significant progress in the delivery of clinical preventive services is unlikely without appropriate data systems. Physicians' practices often lack service tracking systems that could automatically notify patients of the need for routine preventive services.

Unlike other preventive care services, such as cholesterol screening, breast cancer screening, and cervical cancer screening, colorectal cancer screening is not a component of the Health Plan Employer Data and Information Set (HEDIS), a standardized, voluntary HMO performance reporting system developed by the National Committee on Quality Assurance (NCQA).¹⁶ NCQA plays an influential role in prevention by including HEDIS reporting in its accreditation standards. That is, plans seeking accreditation encourage their network physicians to improve the delivery and reporting of measured services.¹⁷ AHRQ, with support from CDC, is working with NCQA and researchers at RAND and the Harvard University School of Public Health to develop measures of colorectal cancer screening that could possibly be included in HEDIS. Developing effective measures to determine whether enrollees are screened appropriately is more challenging because only one of the screening services is recommended annually.

Concluding Observations

Our data suggest that the use of colorectal cancer screening and diagnostic services is quite low among Medicare beneficiaries. There is substantial room for better outreach and education. Consensus on appropriate clinical practice and expansion of coverage to ensure reimbursement are only first steps. In addition to these developments, efforts under way to enhance public awareness of the risks of colorectal cancer and the benefits of screening may result in the greater use of these services over time.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions from you and other members of the Committee.

¹⁶HEDIS data are the most commonly used HMO performance measures for the under-65, employer-insured, HMO population.

¹⁷NCQA accreditation is important to public and private purchasers, who view it as an indicator of HMO quality.

GAO Contact and Acknowledgments

For future contacts regarding this testimony, please call Jan Heinrich, Associate Director, Health Financing and Public Health at (202) 512-7250. Other individuals who made key contributions include Jenny Grover, Rosamond Katz, and Debbie Spielberg.

Medicare Beneficiaries' Use Rates for Colorectal Cancer Screening and Diagnostic Services, 1995–99

The table shows demographic and geographic differences in use rates. The rates represent the percentage of Medicare beneficiaries having a fecal occult blood test, flexible sigmoidoscopy, colonoscopy, or barium enema. The rates include use of these services for screening, diagnostic, and, in the case of colonoscopy, treatment purposes.

	1995	1996	1997	1998	1999
Total	13.6%	13.2%	12.6%	13.1%	14.1%
Gender					
Male	12.8	12.4	11.9	12.1	13.2
Female	14.2	13.8	13.2	13.8	14.8
Race					
White	14.2	13.8	13.3	13.9	14.9
Black	9.0	8.9	8.5	8.4	9.1
Asian	11.8	11.2	8.9	11.2	12.6
Hispanic	8.0	8.2	5.9	7.7	8.1
Other and unknown	10.5	10.5	11.9	9.0	10.6
Age					
Younger than 65	4.6	4.6	4.5	4.5	4.9
65-69	15.0	14.6	13.7	14.7	15.6
70-74	16.6	16.2	15.6	16.3	17.6
75-79	16.8	16.4	15.7	16.4	17.9
80-84	15.2	14.8	14.4	14.8	15.9
85 and older	10.9	10.5	10.3	10.0	11.0
State					
Alabama	15.1	15.1	9.5	10.5	12.4
Alaska	11.1	10.9	8.3	9.9	10.7
Arizona	14.8	11.6	11.4	12.8	14.6
Arkansas	13.3	11.7	9.6	11.1	11.4
California	15.5	15.6	15.4	13.2	14.9
Colorado	6.3	5.9	5.9	9.9	9.6
Connecticut	9.8	9.2	8.7	12.9	15.3
Delaware	15.5	15.5	15.0	15.0	17.1
District of Columbia	16.5	16.0	14.6	13.1	13.8
Florida	15.6	15.6	15.2	16.9	18.6
Georgia	13.6	11.4	10.7	12.1	13.5
Hawaii	15.6	12.9	13.8	16.7	20.3
Idaho	7.4	7.4	7.0	10.2	9.8
Illinois	12.4	12.3	12.0	11.5	11.8
Indiana	6.8	6.5	6.2	10.0	10.5
Iowa	15.5	11.0	7.7	12.1	12.3
Kansas	13.1	9.4	10.7	11.9	12.9
Kentucky	12.1	11.6	11.8	12.5	13.5

Appendix

	1995	1996	1997	1998	1999
Louisiana	7.3	6.7	7.1	8.2	8.8
Maine	17.8	16.9	15.7	16.5	16.9
Maryland	18.2	17.2	17.2	17.0	19.5
Massachusetts	19.4	19.9	19.1	18.3	19.9
Michigan	16.2	16.2	16.3	15.8	15.6
Minnesota	10.6	12.0	12.7	13.7	14.9
Mississippi	10.9	11.1	10.5	10.9	11.9
Missouri	11.4	10.2	10.6	11.9	12.5
Montana	7.8	7.7	7.5	9.1	10.9
Nebraska	10.6	7.0	8.2	9.6	10.7
Nevada	9.7	7.5	8.2	9.0	10.4
New Hampshire	16.6	16.8	15.7	16.9	16.6
New Jersey	15.8	16.0	15.5	14.9	16.1
New Mexico	8.3	8.5	9.1	10.1	8.2
New York	17.2	17.4	15.2	14.4	15.7
North Carolina	13.6	12.9	12.8	12.7	14.2
North Dakota	12.3	8.4	8.0	12.4	11.9
Ohio	14.4	13.5	13.1	12.1	11.4
Oklahoma	10.3	10.6	10.9	12.1	11.9
Oregon	11.8	13.6	11.8	12.0	14.5
Pennsylvania	14.4	14.1	13.7	14.0	15.5
Rhode Island	18.1	19.1	20.2	17.5	17.8
South Carolina	16.2	16.7	15.6	15.4	14.5
South Dakota	12.8	7.1	7.2	10.7	12.8
Tennessee	12.4	12.4	11.8	10.2	10.9
Texas	13.1	13.2	13.1	13.0	14.1
Utah	7.3	6.8	6.6	8.1	10.2
Vermont	17.8	17.0	16.0	16.4	15.6
Virginia	9.7	10.4	10.5	12.8	14.9
Washington	10.5	10.9	11.0	13.5	15.0
West Virginia	11.3	11.2	10.4	10.2	10.4
Wisconsin	7.6	7.7	7.5	11.8	12.9
Wyoming	10.6	8.1	6.7	9.6	10.0

Note: Rates for 1999 are estimated from claims paid January through June 1999.

Source: GAO analysis of Health Care Financing Administration claims data.

(201026)

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**United States
Office of
Personnel
Management**

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**OFFICE OF THE DIRECTOR
1900 E STREET, NW., ROOM 5H09
WASHINGTON, DC 20415-0001**

Date:

12/16

Number of Pages
(including this one)

9

**Please
Deliver
To:**

Name: **Chris Jennings**

Office:

Room:

Telephone:

From:

Name: **Mark Hunker**

Office: **Senior Advisor to the Director**

Room:

Telephone: **(202) 606-1000**

FAX Number: **(202) 606-2076**

Remarks

Chris,

Here is the paper on ~~the~~ Leave for Cancer and Other Preventive Screenings. As you and Director Lachance dicussed at the Medical Errors event, this report is over due and might be a good event before the budget release.

We are also sending this to Sarah.

Mark Hunker



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

MEMORANDUM FOR THE VICE PRESIDENT OF THE UNITED STATES

FROM:

Janice R. Lachance
Director

SUBJECT:

Leave for Cancer and Other Preventive Screenings

The many benefits of health education and preventive health screenings are well-known to the American people and the medical care profession. As the single largest employer in the Nation, we are proposing a work-site initiative for Federal employees that would provide for a wider variety of preventive health measures and one that would provide increased excused absence for those employees who, we believe, would benefit most.

The genesis for this new initiative was your August 10, 1999, directive to the Office of Personnel Management (OPM) to look into the advisability and feasibility of giving Federal employees time off from work each year for cancer and other preventive screenings.

We are convinced that any effort to increase the level of employee participation in health screening activities must be part of a comprehensive preventive health services program that includes not only screenings, but health education, counseling, and intervention. A growing body of literature links some of the leading causes of death in America to a handful of personal health behaviors such as smoking, failing to use seat belts, driving while intoxicated, physical inactivity, dietary factors, and high risk sexual practices. Changing personal health behaviors before disease develops also plays a vital role in maintaining good health. By providing comprehensive preventive health services at the work-site, without charge to leave, agencies can help employees identify their risk for disease, evaluate their health care needs, and make healthy lifestyle choices.

According to the Bureau of Labor statistics 1997 figures, 34 percent of employees in large establishments in the non-Federal sector are offered some type of health promotion program. However, most Federal agencies provide pertinent health care information to their employees through activities such as smoking cessation clinics, exercise/physical fitness programs, weight control programs, nutrition education, hypertension tests, and stress management courses. Many agencies offer health fairs which allow employees to conveniently explore, under one roof, resources related to the health issues that are of particular concern to them.

We believe the Federal Government's leave system is sufficient to accommodate most Federal employees' needs for participation in screenings and other preventive health activities. (Attachment 1 provides more detail about time off for cancer and other preventive screenings in the Federal and non-Federal sectors.) Nevertheless, we are concerned about those Federal

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employees who have not worked long enough to accrue a substantial balance of paid sick leave or who have been forced to use most or all of their paid sick leave as a result of previous illnesses or periods of incapacitation. In these cases, we believe it would be appropriate for agency heads to provide up to 4 hours of excused absence with pay each year to participate in preventive health screenings not directly sponsored by the agency.

We have prepared a memorandum from the President (Attachment 2) that directs agencies to review their leave and work schedule policies and to inform employees of the various flexibilities available to them for arranging to participate in screening activities. In the case of employees with less than 3 years of service or fewer than 80 hours (2 weeks) of accrued sick leave, the memorandum asks agencies to provide up to 4 hours of excused absence each year, without loss of pay or charge to leave, for participation in preventive health screenings not directly sponsored by the agency. The memorandum also asks agencies to expand or develop programs offered at the work-site that help employees understand their risks for disease, obtain preventive health services, and make healthy lifestyle choices. We will provide departments and agencies with appropriate guidance on developing preventive health initiatives. In addition, it requests agencies to share their best practices and preventive health initiatives with OPM within 120 days. OPM will use this information to identify and share agency best work-site practices.

Your request was based upon a program implemented in Boston that gives city employees 4 hours off annually for cancer screenings. We have researched the issue and consulted with colleagues from the Department of Health and Human Services (HHS). This effort has resulted in our proposed initiatives that are designed to help our employees remain both healthy and productive.

It is important to note that, under the Federal Employees Health Benefits (FEHB) Program, insurance carriers are required to cover mammography, prostate-specific antigen, and colorectal screening. Many carriers cover other screenings as well. OPM will continue to monitor the screening recommendations adopted by authoritative bodies such as the National Cancer Institute and we will assure that the FEHB Program provides appropriate benefits.

The issue of employee health is one of deep concern to me and to OPM. We appreciate your support in calling the Nation's attention to this important issue.

Attachments

Attachment 1

Time Off for Cancer and Other Preventive Screenings in the Federal Government

The Federal personnel system provides employees with considerable flexibility in scheduling their hours of work and taking time off for medical needs, including routine examinations and preventive screenings. Examples of the work and leave flexibilities available to employees for screenings include the following:

- **Alternative Work Schedules.** Federal agencies may establish flexible or compressed work schedules, collectively referred to as "alternative work schedules." Alternative work schedules allow for a variety of working arrangements tailored to fit the needs of individual employees.
- **Annual leave.** Most employees accrue 13, 20, or 26 days of annual leave each year, depending on years of service (which accumulates to a maximum of 240 hours each year).
- **Excused Absence.** Agencies may grant excused absence to employees to participate in agency sponsored preventive health activities, such as health fairs, mobile health van screenings, and smoking cessation and stress reduction classes. Agencies should also establish a policy that provides employees with less than 3 years of service or fewer than 80 hours (2 weeks) of accrued sick leave with up to 4 hours of excused absence each year, without loss of pay or charge to leave for participation in preventive health screenings not directly sponsored by the agency.
- **Sick leave.** Most employees accrue 13 days of sick leave each year without regard to length of service (which accumulates without limit in succeeding years).
- **Advance leave.** Supervisors may advance annual and sick leave to employees who do not have available paid leave and have already used 4 hours of excused absence for preventive health screenings not directly sponsored by the agency. In addition, supervisors may advance annual and sick leave to employees for additional examinations and follow-up treatments.

When an employee needs additional medical attention, e.g., a serious health condition is identified by a screening process, the following additional leave programs are available:

- **The Family and Medical Leave Act of 1993 (FMLA).** Under the FMLA, an employee is entitled to a total of 12 workweeks of unpaid leave during any 12-month period for certain needs, including an employee's serious health condition and screenings for such conditions. An employee may substitute annual leave or sick leave, as appropriate, for unpaid leave under the FMLA.

Attachment 1 continued

Leave Sharing. Employees who experience a personal or family medical emergency and who exhaust their available paid leave may receive donated annual leave from other Federal employees through the voluntary leave transfer or leave bank programs.

Information on these programs is available on OPM's web site at www.opm.gov/oca.

Time Off for Cancer and Other Preventive Screenings in the Non-Federal Sector

The Bureau of Labor Statistics (BLS) reported that in 1997 only 56 percent of full-time employees in establishments with 100 or more employees receive paid sick leave. The average number of sick leave days available after 1 year of service was 11 days, with 21 days available after 25 years. In the large establishments surveyed, 39 percent of employees could not accumulate sick leave in succeeding years, 19 percent were allowed unlimited accumulation, and the remainder were limited to a maximum accumulation of sick leave, most often in the 30-39 day range.

In comparison, Federal employees accrue 13 days of sick leave each year without regard to length of service and may accumulate sick leave in succeeding years without limitation. The average use of sick leave by Federal employees in 1998 was 9.47 days. Assuming a Federal employee uses the average amount of sick leave each year, he or she can accumulate 18 days of sick leave after 5 years of service, 35 days after 10 years, and 88 days after 25 years.

Attachment 2

THE WHITE HOUSE
WASHINGTON

DRAFT

MEMORANDUM FOR THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

SUBJECT: Preventive Health Services at the Federal Workplace

I have been heartened by progress in preventive research into cancer and other serious diseases. Vice President Gore announced recently, on the second anniversary of the Cancer Genome Anatomy Project, that over 30,000 human genes predisposing individuals to cancer have been identified, more than double the original goals, and that 8.4 million Americans have survived cancer. This is good news indeed.

I am still concerned about another front in the war against disease. We know a great deal about screening procedures that can detect diseases early, and about behaviors, such as smoking cessation and sun avoidance, that can greatly reduce a person's risk of disease. The challenge that remains is to ensure that all Americans not only take advantage of the screening programs and other effective preventive measures that are available and appropriate, but that they make positive changes in their lifestyle before disease develops. For example, Healthy People 2010, a forthcoming report on our Nation's health objectives, estimates that as much as 50 percent or more of a cancer incidence can be prevented through smoking cessation and improved dietary habits such as reducing fat consumption and increasing intake of fruits and vegetables.

The workplace is a logical place to provide employees with health information and services to help employees learn about preventive health. The Federal Government, the Nation's largest employer, has already developed many effective measures for encouraging preventive health care for its employees. These measures, available to all Federal employees, cover a broad range of preventive health services, including screening for prostate, cervical, colorectal, and breast cancer and screening for sickle cell, blood lead level, and blood cholesterol level, as well as all recommended childhood immunizations, well child care, and adult preventive care visits. In addition, the Federal personnel system provides employees with considerable flexibility in scheduling their hours of work and taking time off for medical needs, including routine examinations and preventive screenings. Many agencies offer creative, effective employee health programs that provide opportunities for employees to take advantage of preventive health screenings at the worksite.

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There is still room for progress. Therefore, I am today asking Federal departments and agencies to review their policies and make maximum use of existing work schedule and leave flexibilities to allow Federal employees to take advantage of screening programs and other effective preventive health measures. Each department and agency should also inform its employees of the various work schedule and leave flexibilities available to them to participate in these preventive screenings and examinations. Such flexibilities include promoting alternative work schedules (flexible and compressed work schedules), which allow for a variety of working arrangements tailored to fit the needs of individual employees, granting leave under the Federal Government's sick and annual leave programs, and granting excused absence to employees to participate in agency sponsored preventive health activities. In the case of employees with less than 3 years of service or fewer than 80 hours (two weeks) of accrued sick leave, I am asking each department and agency to establish a policy that provides up to four hours of excused absence each year, without loss of pay or charge to leave, for participation in preventive health screenings not directly sponsored by the agency.

I am also asking agencies to develop or expand programs offered at the worksite to help employees understand their risks for disease, obtain preventive health services, and make healthy lifestyle choices and to share these initiatives with the Office of Personnel Management (OPM) within 120 days. OPM will use this information to identify and share agency best worksite practices. Finally, I direct the OPM to prepare guidance to assist agencies in carrying out this directive.

I want the Federal Government to serve as a model for the rest of the country. While Federal agencies have led the way in many instances, I want to go even further in demonstrating that preventive health care for all employees is not only desirable, but also very practical and sensible.

WILLIAM J. CLINTON

DRAFT



**UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001**

OFFICE OF THE DIRECTOR

DRAFT

MEMORANDUM FOR HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

**FROM: Janice R. Lachance
Director**

**SUBJECT: Promoting Preventive Health Programs and Screenings for
Federal Employees**

Many of the leading causes of death and disability in the United States are largely preventable through early detection, intervention, and changes in behavior. Preventive health care is necessary to meet our challenge to become a healthier nation. Because most working Americans spend at least 30 percent of their time at work, the workplace is a logical place for employees to receive preventive health information and services.

On December XX, 1999, President Clinton signed the attached memorandum to heads of departments and agencies asking that you:

- (1) Review your policies and make maximum use of existing work schedule and leave flexibilities to allow Federal employees to take advantage of screening programs and other preventive health measures. Each department and agency should also inform its employees of the various work schedule and leave flexibilities available to them to participate in screenings and other preventive health measures. Such flexibilities include promoting alternative work schedules (flexible and compressed work schedules), which allow for a variety of working arrangements tailored to fit the needs of individual employees; granting leave under the Federal Government's sick and annual leave programs; and granting excused absence to employees to participate in agency sponsored preventive health activities. In the case of employees with less than 3 years of service or fewer than 80 hours (two weeks) of accrued sick leave, agencies should establish a policy that provides up to four hours of excused absence each year, without loss of pay or charge to leave, for participation in preventive health screenings not directly sponsored by the agency.
- (2) Develop or expand programs offered at the worksite to help employees understand their risks for disease, obtain preventive health services, and make healthy lifestyle choices. We will be issuing a guide in the near future to assist agencies in promoting preventive health care for all employees.
- (3) Share your preventive health initiatives with the Office of Personnel Management (OPM) within 120 days. OPM will use this information to identify and to provide practical information on agency best worksite practices.

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As requested by the President, please submit your preventive health initiatives by **xx**, 2000 to:

Anice V. Nelson, Director
Family-Friendly Workplace Advocacy Office
U.S. Office of Personnel Management
1900 E Street NW., Room 7315
Washington, DC 20415-2000
Telephone: (202) 606-2011
Fax: (202) 606-2091
Email: avnelson@opm.gov.

Through these efforts, we hope to encourage our workforce to take advantage of the screening programs and other preventive health measures that can make a real difference in the lives of Federal employees.

Attachment

DRAFT

THE WHITE HOUSE
WASHINGTON

Chris Jennings / Devoran Adler
x6-5557

February 24, 2000

MEMORANDUM FOR:

FIRST LADY'S STAFF (MELANNE VERVEER)
SEAN MALONEY (LISEL LOY)
BETH NOLAN
THURGOOD MARSHALL, JR.
CHUCK BRAIN
✓ BRUCE REED
MARY BETH CAHILL
MINYON MOORE
MARK LINDSAY
STEPHANIE STREETT - FYI

FROM:

Eileen McCaughey/Maureen Hudson
for DAN BURKHARDT

SUBJECT:

(Draft Proclamation)
National Colorectal Cancer Awareness
Month, 2000

Attached for your review is the above-mentioned proclamation designating March 2000 as "National Colorectal Cancer Awareness Month, 2000."

It was submitted by the Cancer Research Foundation and edited/revised by the Presidential Letters and Messages Office.

IMMEDIATE ATTENTION REQUIRED. Written or oral response required by no later than 10:00 A.M., Monday, February 28, 2000. IF WE HAVE NOT HEARD FROM YOU BY 10:00 A.M., WE WILL ASSUME THAT THE DRAFT IS ACCEPTABLE TO YOU.

For questions, discussion, or routine clearance, contact Eileen McCaughey, extension 65494, or Maureen Hudson, extension 65902, via phone or interoffice mail, in room 91. Thank you.

cc: Tim Saunders

NATIONAL COLORECTAL CANCER AWARENESS MONTH, 2000

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BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

Colorectal cancer is the second leading cause of cancer-related deaths in the United States. Estimates show that physicians will diagnose approximately 130,000 new cases of colorectal cancer this year, and, of those persons diagnosed, more than 56,000 will die from the disease. Colorectal cancer takes such a deadly toll because it usually has no identifiable symptoms and too often goes undetected before it is too late.

Our most effective weapon in defeating colorectal cancer is early detection and treatment. Through a regular screening program that includes fecal blood testing, periodic partial or full colon examinations, or both, health professionals can detect and remove pre-cancerous polyps before they turn into cancer. Such cancer screening should become a routine part of preventive health care for anyone over the age of 50, because the risk of developing colorectal cancer increases with age. Individuals with a personal or family history of inflammatory bowel disease, colorectal cancer or polyps, or ovarian, endometrial, or breast cancer are also at a higher risk for developing colorectal cancer.

We can draw hope from the progress that is being made in colorectal cancer research. The National Cancer Institute of the National Institutes of Health recently launched a large research study to test two of the most promising drugs to treat colorectal cancer, and new technologies are giving us more powerful tools to increase the ease and accuracy of colorectal screening. By continuing to support such research, raising awareness of risk factors for the disease, promoting the widespread adoption of regular screening, and encouraging everyone to maintain a healthy exercise regularly, we can save thousands of lives each year and dramatically reduce the risk of developing colorectal cancer.

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NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim March 2000 as National Colorectal Cancer Awareness Month. I encourage health care providers, advocacy groups, policymakers, and concerned citizens across the country to help raise public awareness of the risks and methods of prevention of colorectal cancer and to use the power of our knowledge to defeat this silent disease.

IN WITNESS WHEREOF, I have hereunto set my hand this
day of , in the year of our
Lord two thousand, and of the Independence of the United States
of America the two hundred and twenty-fourth.