Center, Hope House, the College of Saint Elizabeth, Centenary College, the United Way, the Easter Seal Society and even the Governor's Advisory Council for Drug/Alcohol Abuse. However, nowhere is her presence more evident than at the Dope Open, Inc., of which she is the founder and president. In three decades with the Dope Open, she has, through her charming personality, conviction and absolute tenacity, raised more than $1 million to fight drug abuse and chemical dependency. Each year, Mary continues her relentless battle to help juveniles in our community who have been robbed of their youth and innocence by the scourge of drugs. The Dope Open provides hope for these lost children and I am certain that without Mary's foresight, fortitude and dedication to this effort, many of them would have nowhere to turn.

The one thing everyone who knows Mary can agree on is that a person cannot help but be energized into action when she speaks. When Mary decides to take on a commitment to help people in our community, she installs in all of us a sense of urgency about the issue—a sort of call to arms. And Mary is no figurehead, she provides both the spark, dynamism and energy needed to take on any task, no matter how daunting or demanding. To that end, she does us all a public service by bringing out our own compassion and sense of duty to help our less fortunate neighbors.

Mr. Speaker, each day, thanks to the Herculean efforts of Mary Mulholland, the future of Morris County is a little more promising. Mary Mulholland truly embodies the spirit of service and I thank her for all she has done for our community throughout the years.

PERSONAL EXPLANATION

HON. BOBBY L. RUSH

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, March 19, 1997

Mr. RUSH. Mr. Speaker, on March 5, 1997, I voted ''aye'' for rollcall No. 31, which expressed the sense of Congress that the display of the Ten Commandments in public buildings should be allowed. My vote was based on my personal brief in the Ten Commandments as a basic fundament of Christian doctrine. After further examination I came to the realization that, in spite of my personal beliefs, I must recognize that one's personal beliefs, including my own, cannot usurp the tenets which our country is based upon. One of those tenets is the separation of church and state. This measure is in direct opposition to the aforementioned principle. Thus, I would like the RECORD to reflect that I am not in support of this measure.

PRESERVE THE ILLINOIS AND MICHIGAN CANAL

HON. WILLIAM O. LIPINSKI

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, March 19, 1997

Mr. LIPINSKI. Mr. Speaker, on February 12, I introduced legislation to preserve and enhance the Illinois and Michigan Canal National Heritage Corridor. H.R. 1042 extends the I&M Canal National Heritage Corridor Commission for another 5 years to 2004.

Designated by Congress in 1984, the I&M Canal National Heritage Corridor was the first ''partnership park'' of its kind and is now a model for such parks throughout the Nation. The Corridor stretches 100 miles across Illinois, from Chicago to LaSalle/Peru and encompasses 450 square miles. Its rich heritage and recreational opportunities attract countless visitors to the area and enhance the pride of local residents. Simply put, the Corridor is of great historical significance to the State of Illinois, as well as the entire Nation.

Since the creation of the Commission, which coordinates the efforts and resources of Federal, State, and local agencies, we have seen significant progress being made along the Corridor. However, there is still a great deal more that needs to be done. We must continue to work to preserve this unique treasure for future generations. H.R. 1042 will allow the Commission to continue its vital work and further the successful partnership between Federal, State, and local agencies as they work to preserve this important piece of our Nation's history.

I strongly urge my colleagues to support my bill, H.R. 1042.

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HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, March 19, 1997

Mr. GREEN. Mr. Speaker, it is very seldom that I get the opportunity to recognize local personalities who have unselfishly devoted their time and effort to improve the world we live in. In Houston we are fortunate to have someone like Sam Malone. Sam Malone has been firing up the radio waves for 4 years in Houston with his cohosts of the ''Morning Show'' Maria Todd and Psychoo Robbie on 104 KRBE. Aside from providing lively entertainment, they have held numerous charity events to help our city, including blood drives, food drives, and clothing drives. In recognition of their 4th year anniversary, I would like to take this opportunity to thank Sam and the ''Morning Show'' for their hard work and commend everyone at KRBE for their continued support to our organizations and charities.

Here's to you Sam, happy anniversary, we look forward to many more years to come. See ya.

THE COLORECTAL CANCER SCREENING ACT OF 1997

HON. ALCEE L. HASTINGS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, March 19, 1997

Mr. HASTINGS of Florida. Mr. Speaker, I am today introducing the Colorectal Cancer Screening Act of 1997 in order to establish colorectal cancer screening as a covered benefit under the Medicare program. Colorectal cancer screening is an important element of what should be a comprehensive program of preventive health care for our senior citizens. Unfortunately, the current Medicare program provides little incentive for Medicare recipients to have regular check-ups and undergo the routine tests that will prevent serious illnesses and detect diseases at their earliest, most treatable stage. This legislation, if enacted, would encourage Medicare recipients to be screened for colorectal cancer by providing Medicare coverage of those tests. I am pleased to be joined by 14 cosponsors in introducing this important legislation.

It is particularly timely that this legislation be considered at this time. Over the past 2 to 3 years, there has been a significant amount of work done within the medical community to develop Guidelines and recommendations on how to screen for colorectal cancer. Several new screening guidelines and revised screening recommendations have been released within the past two months, and new screening recommendations are expected to be issued within the next few weeks by the American Cancer Society. These Guidelines and recommendations indicate that there is an emerging consensus that there are a number of different procedures that can be used to screen for colorectal cancer. This legisaltion is based upon that consensus.

The move to develop new screening guidelines really started in the spring of 1995 with the release of the ''Guide to Clinical Preventive Services'' by the U.S. Preventive Services Task Force. In this report, the Task Force reversed the position taken in its 1989 report and concluded that there was a sufficient scientific basis upon which to recommend colorectal cancer screening, starting at age 50 for most individuals. The report specifically recommended screening average risk individuals with two procedures—FOBT and sigmoidoscopy—though it raised concerns about the limited effectiveness of these procedures and questioned the willingness of patients to comply with these tests. The report also noted discussed screening with colonoscopy and the barium enema, and concluded that there was insufficient evidence to recommend for or against screening with either test. The report also raised questions regarding the overall cost and risks of screening, particularly with regard to colonoscopy.

Many of the questions raised by the U.S. Preventive Services report have been answered. The release of the Task Force report prompted the Agency for Health Care Policy and Research [AHCPR] of the Department of Health and Human Services to initiate a 2-year project to examine the scientific and medical literature on all available options for colorectal cancer screening and to develop Clinical Practice Guidelines on colorectal cancer screening. The AHCPR terminated the development of specific screening recommendations last April, but has completed an ''Evidence Report'' summarizing the current evidence on the various screening procedures. A summary of this report, released in February, concludes that there is evidence to support colorectal cancer screening with all of the screening procedures identified in the Preventive Services Task Force report—FOBT, sigmoidoscopy, the barium enema and colonoscopy. I ask unanimous consent that the Summary of the AHCPR Evidence Report be included in the RECORD with these remarks.

The effort to develop Clinical Guidelines for Colorectal Cancer Screening did not, however, end with AHCPR's decision not to complete

the project. Colorectal Cancer Screening Guidelines based on the AHCPR project were completed and published in the February 1997 issue of the medical journal ''Gastroenterology.'' The 16 members of the multidisciplinary expert panel first assembled by the AHCPR were listed as the authors of the Guidelines, and the project was completed under the direction of the American Gastroenterological Association and a consortium of four other gastroenterology organizations that had served as the contractor to the AHCPR. These new Guidelines are endorsed by the American Cancer Society, American College of Gastroenterology, American Gastroenterological Association, American Society of Colon and Rectal Surgeons, American Society for Gastrointestinal Endoscopy, Crohn's and Colitis Foundation of America, Oncology Nursing Society and the Society of American Gastrointestinal Endoscopic Surgeons.

The Colorectal Cancer Screening Act of 1997 embodies the screening recommendations included in the clinical Guidelines and supported by the AHCPR Evidence Report. It should be noted that the legislation includes the option for individuals at average-risk and high-risk to be screened with the barium enema. It does so because providing patients and their physicians with the option of being screened with the barium enema is fully supported by these reports, and by the scientific and medical literature that provides the basis for the recommendations. To be specific with regard to the Clinical Practice Guidelines published in Gastroenterology:

The Clinical Practice Guidelines recommend screening people at average risk for colorectal cancer with double-contrast barium enema every 5–10 years;

The Clinical Practice Guidelines recommend use of the barium enema for screening individuals at high risk for colorectal cancer—individuals with close relatives who have had colorectal cancer or an adenomatous polyp and people with a family history of hereditary nonpolyposis colorectal cancer—and

The Clinical Practice Guidelines recommend use of the barium enema or colonoscopy for surveillance of people with a history of adenomatous polyps or colorectal cancer.

Although they have not yet been finalized, I understand that the American Cancer Society will soon issue new recommendations for colorectal cancer screening. The legislation that I introduce today is consistent with the approach that has been taken by the American Cancer Society in developing these new recommendations.

One final consideration guided the development of this colorectal cancer screening legislation, and it is that the colorectal cancer is a particularly deadly disease for African-Americans. This is discussed in the Summary of the AHCPR Evidence Report, which notes that the National Cancer Institute and other medical journals have found that black men and women with colorectal cancer have a 50 percent greater probability of dying of colon cancer than do white men and women. The medical literature indicates that this is caused, at least in part, by the fact that African-Americans tend to get colorectal cancer in the right—proximal—portion of the colon—the portion that is not reached by sigmoidoscopy, the most common screening procedure currently in use. The Colorectal Cancer Screening Act of 1997 provides individuals the option of a full colon screening with the barium enema in order to assure that the screening program we establish in the Medicare program is adequate for African-Americans. It also should be noted that this option is particularly important for other Americans as well, given that it has been shown to be significantly more effective than screening only one-half of the colon with sigmoidoscopy. Moreover, in addition to being effective, the barium enema is one of the most cost-effective screening procedures for both average-risk and high-risk individuals.

In conclusion, I would like to emphasize for my colleagues the cost-effectiveness of this legislation. According to the Office of Technology Assessment, colorectal cancer screening is capable of saving thousands of American lives at a cost of only about $13,250 per life year saved. Colorectal cancer screening is also cost-effective when compared with other Medicare-covered procedures such as kidney dialysis—$50,000 per life year saved—and mammography—$40,000 per life year saved. I cite these figures not to argue against these other life-saving devices and procedures, but rather to provide a comparison that demonstrates the importance of Medicare coverage for such cost-effective procedures as colorectal cancer screening at a time when we are working hard to reduce the level of spending in the overall Medicare program.

In the end, however, the Colorectal Cancer Screening Act of 1997 is not about cost-effectiveness and economics—it is about saving lives that are unnecessarily lost to this disease. Colorectal cancer strikes about 145,000 Americans each year, and about 55,000 Americans die of the disease each year. This legislation can save many of these lives, and I urge my colleagues to join me in seeking its enactment.

THE INTRODUCTION OF THE HISTORIC HOMEOWNERSHIP ASSISTANCE ACT

HON. E. CLAY SHAW, JR.

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, March 19, 1997

Mr. SHAW. Mr. Speaker, all across America, in the small towns and great cities of this country, our heritage as a nation—the physical evidence of our past—is at risk. In virtually every corner of this land, homes in which grandparents and parents grew up, communities and neighborhoods that nurtured vibrant families, schools that were good places to learn and churches and synagogues that were filled on days of prayer, have suffered the ravages of abandonment and decay.

In the decade from 1980 to 1990, Chicago lost 41,000 housing units through abandonment, Philadelphia 10,000, and St. Louis 7,000. The story in our older small communities has been the same, and the trend continues. It is important to understand that it is not just the buildings that we are losing. It is the sense of our past, the vitality of our communities and the shared values of those precious places.

We need not stand hopelessly by as passive witnesses to the loss of these irreplaceable historic resources. We can act, and to that end I am introducing today with my colleagues, Mrs. Kennelly, Mr. Lewis, Mrs. Johnson of Connecticut, and Mr. English, the Historic Homeownership Assistance Act.

This legislation is almost identical to legislation introduced in the 104th Congress as H.R. 1662. It is patterned after the existing Historic Rehabilitation Investment tax credit. That legislation has been enormously successful in stimulating private investment in the rehabilitation of buildings of historic importance all across the country. Through its use we have been able to save and re-use a rich and diverse array of historic buildings: landmarks such as Union Station in Washington, D.C.; the Fox Paper Mills, a mixed-used project that was once a derelict in Appleton, WI; and the Rosa True School, an eight-unit low/moderate income rental project in an historic building in Portland, Maine. In my own State of Florida, since 1974, the existing Historic Rehabilitation Investment Tax Credit has resulted in over 325 rehabilitation projects, leveraging more than $238 million in private investment. These projects range from the restoration of art deco hotels in historic Miami Beach, bringing economic rebirth to this once decaying area, to the development of multifamily housing in the Springfield Historic District in Jacksonville.

The legislation that I am introducing today builds on the familiar structure of the existing tax credit but with a different focus. It is designed to empower the one major constituency that has been barred from using the existing credit—homeowners. Only those persons who rehabilitate or purchase a newly rehabilitated home and occupy it as their principal residence would be entitled to the credit that this legislation would create. There would be no passive losses, no tax shelters, and no syndications under this bill.

Like the existing investment credit, the bill would provide a credit to homeowners equal to 20 percent of the qualified rehabilitation expenditures made on an eligible building that is used as a principal residence by the owner. Eligible buildings would be those that are listed on the National Register of Historic Places, are contributing buildings in National Register Historic Districts or in nationally certified state or local historic districts or are individually listed on a nationally certified state or local register. As is the case with the existing credit, the rehabilitation work would have to be performed in compliance with the Secretary of the Interior's standards for rehabilitation, although the bill would clarify the directive that the standards be interpreted in a manner that takes into consideration economic and technical feasibility.

The bill also makes provision for lower-income home buyers who may not have sufficient federal income tax liability to use a tax credit. It would permit such persons to receive a historic rehabilitation mortgage credit certificate which they can use with their bank to obtain a lower interest rate on their mortgage. The legislation also permits home buyers in distressed areas to use the certificate to lower their down payment.

The credit would be available for condominiums and co-ops, as well as single-family buildings. If a building were to be rehabilitated by a developer for sale to a homeowner, the credit would pass through to the homeowner. Since one purpose of the bill is to provide incentives for middle-income and more affluent families to return to older towns and cities, the bill does not discriminate among taxpayers on the basis of income. It does, however, impose