CALIFORNIA HEALTH PLAN COLORECTAL CANCER SCREENING LEARNING COLLABORATIVE



Kick-Off Session
Tuesday, August 25, 2026

American Cancer Society

California Colorectal Cancer Coalition

CDCC California Dialogue on Cancer
California's Coalition to Prevent Cancer and Save Lives

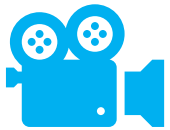
Housekeeping



ALL PARTICIPANTS HAVE BEEN MUTED. TO ASK A QUESTION, PLEASE UNMUTE YOURSELF



PLEASE ASK QUESTIONS BY UNMUTING, USING THE CHATBOX, OR Q&A



THIS SESSION IS BEING RECORDED & SLIDES WILL BE PROVIDED



THE EVALUATION LINK WILL BE DROPPED IN THE CHAT. PLEASE COMPLETE TO HELP US IMPROVE FUTURE SESSIONS.

American Cancer Society

California Colorectal Cancer Coalition

CDCC California Dialogue on Cancer

Agenda

- Welcome & background
- Survivor perspective: Meredith Huetter
- Remarks from DHCS: Julie Pham, MD
- Didactic Presentation: T.R. Levin, MD, MS
- Brief Discussion
- Resources
- Next steps
- Close

American Cancer Society
California Colorectal Cancer Coalition
CDCC California Dialogue on Cancer

Welcome & thank you for joining us!

CA Health Plan Colorectal Cancer Screening Learning Collaborative



American Cancer Society

California Colorectal Cancer Coalition

CDCC California Dialogue on Cancer
California's Coalition to Prevent Cancer and Save Lives

Who's with us?

17 CA Health Plans

Alameda Alliance for Health
Anthem Blue Cross
Blue Shield of California
CalOptima Health
CenCal Health
Central California Alliance for Health
Contra Costa Health Plan
Gold Coast Health Plan
Health Net
IEHP
Kaiser Permanente
Kern Family Health Care
L.A. Care
Molina Healthcare
Partnership HealthPlan
Valley Health Plan
Western Health Advantage

Roles & Departments

Quality Improvement
Population Health
Health Equity
HEDIS & Quality Analytics
Health Education
Provider Relations
Care Management
Clinical Leadership

Expert Faculty & Partners

California Colorectal Cancer Coalition (C4) Board Members
American Cancer Society (ACS)
California Dialogue on Cancer (CDOC)
California Department of Health Care Services (DHCS)
Covered California

Why we are here

There will be an estimated 16,650 new colorectal cancer cases and 5,660 deaths in California this year.

Colorectal Cancer is now the leading cause of cancer deaths for Americans younger than 50.

Colorectal cancer screening offers the opportunity for both prevention and early detection.

Not enough Californians are being screened.

Health plans play a critical role in advancing life-saving CRC Screening.

Pilot: Health Plan CRC Screening Learning Collaborative

- Statewide learning collaborative to support California health plans in improving colorectal cancer screening rates within their enrolled populations.
- Designed to **build knowledge and capacity** among health plan teams working to advance colorectal cancer screening
- **Seven virtual sessions** from August 2026 to April 2027
- Sessions will include **expert presentations, health plan case studies, facilitated discussion**
- Focus on **Medi-Cal Managed Care Plans** but open and relevant to **all California health plans.**
- Participants are health plan team members with a role to play to advance CRC Screening.
- Optional individualized technical assistance is available from ACS/ C4/ and CDOC

American Cancer Society
California Colorectal Cancer Coalition
CDOC California Dialogue on Cancer

CA Health Plan CRC Learning Collaborative Planning Committee

Raquel Arias, MPH
American Cancer Society



Bridget Freeley
American Cancer Society



Margaret Hitchcock, PhD
California Colorectal Cancer Coalition (C4)



Stonewall Anderson, MD
California Colorectal Cancer Coalition (C4)





Shauntay Davis-Patterson, MPH
CA Dept. Public Health
Comprehensive Cancer Control Program



Joyce Ceja, MPH
CA Dept. Public Health
Comprehensive Cancer Control Program
CA Dialogue On Cancer



Sheila Seno-Gerhart, MPH
CA Dept. Public Health
Comprehensive Cancer Control Program
CA Cancer Registry

American Cancer Society
California Colorectal Cancer Coalition
CDCC California Dialogue on Cancer

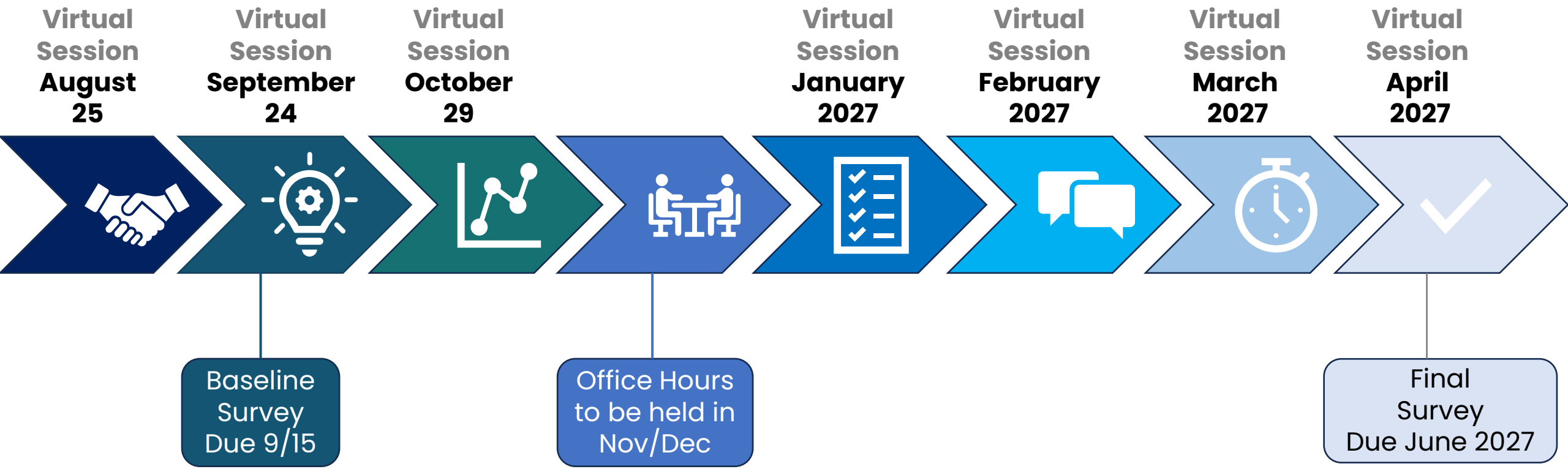
Learning Collaborative Objectives

By the end of the CA Health Plan CRC Screening Learning Collaborative, participants will be able to:

- Apply evidence-based strategies to improve colorectal cancer screening rates across health plan populations.
- Use data to identify screening gaps, prioritize populations for intervention, and monitor performance over time.
- Implement and strengthen health plan-led approaches to advance screening, including population-based outreach, member engagement, provider engagement, and care coordination.
- Improve follow-up after abnormal screening results through effective tracking, navigation, and provider collaboration.
- Identify opportunities to reduce disparities in colorectal cancer screening and follow-up using data-driven and culturally responsive approaches.
- Adapt promising practices and lessons learned from peer health plans to their own organizational context.

American Cancer Society
California Colorectal Cancer Coalition
CDCC California Dialogue on Cancer

Learning Collaborative Timeline



American Cancer Society
California Colorectal Cancer Coalition
CDCC California Dialogue on Cancer









Meredith Huetter

Rectal Cancer Survivor and Advocate

Organizational Affiliates: C4 Unfiltered & FightCRC



CA Colorectal Cancer Health Plan Learning Collaborative

Department of Health Care Services Collaboration

Julie Pham, DO MPH

August 25, 2026

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Importance of Cancer Screening



Colorectal CA is a leading cause of morbidity and mortality in both men and women.

Cancer screening is a powerful tool for early detection, helping save lives and improve long-term outcomes.

USPSTF Grade A/B recommendations reinforce the importance of routine screening.

Improving Colorectal CA Screening Rates (COL-E): Accountability & Strategies



In MY2024**, CA's MCP weighted average for COL-E was 44.22%,** compared to the **national average of 41.93%**



For MY2026 MCAS, **DHCS moved COL-E from a report-only measure to an accountable measure.**



Prioritize data-driven gap identification, evidence-based interventions, and provider collaboration to accelerate improvement.

Thank you for your partnership!

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES



Health Plan CRC Learning Collaborative: Setting the Stage

T.R. Levin, MD, MS

Clinical Lead for CRC Screening, TPMG
Associate Director for Cancer Research, KPNC Division of Research
Vice President, California Colorectal Cancer Coalition (C4)

Outline

- Brief overview of colorectal cancer burden
- Screening gaps: Medi-Cal Performance
- Brief Review of screening modalities
- Follow up After Non-Invasive Tests
- Important role that health plans play
- What works?

CRC Burden

Estimated New Colorectal Cancer Cases and Deaths, 2026, US

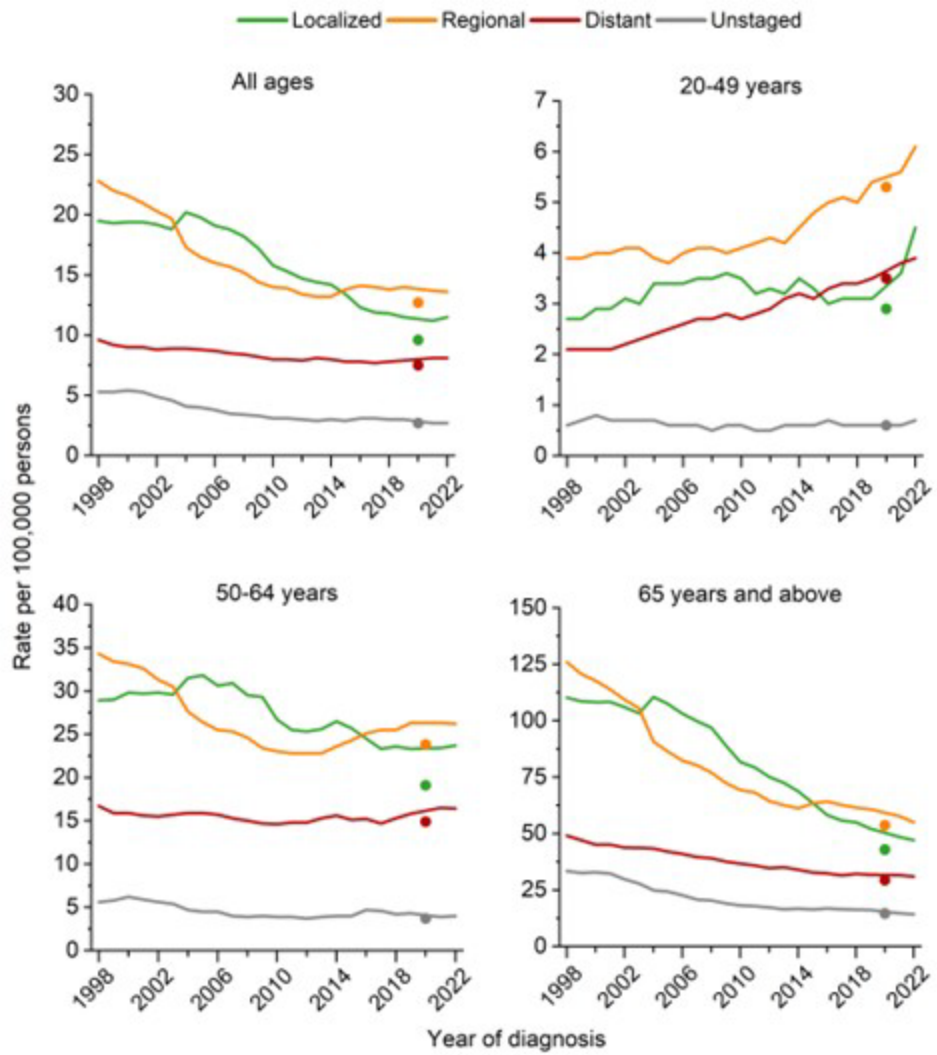
New colorectal cancer cases		
Age, years	**Total**	**Percent**
0 – 49	24,640	16%
50-64	47,600	30%
65+	86,610	55%
All ages	**158,850**	**100%**

Colorectal cancer deaths		
Age, years	**Total**	**Percent**
0 – 49	3,890	7%
50-64	13,480	24%
65+	37,860	69%
All ages	**55,230**	**100%**

Cases include appendiceal cancer. Colon and rectal cancer deaths are not presented separately due to large rates of misclassification.

Citation: Siegel RL, Wagle NS, Star J, Kratzer TB, Smith RA, Jemal A. Colorectal cancer statistics, 2026. CA Cancer J Clin. 2026;e70067. doi:10.3322/caac.70067

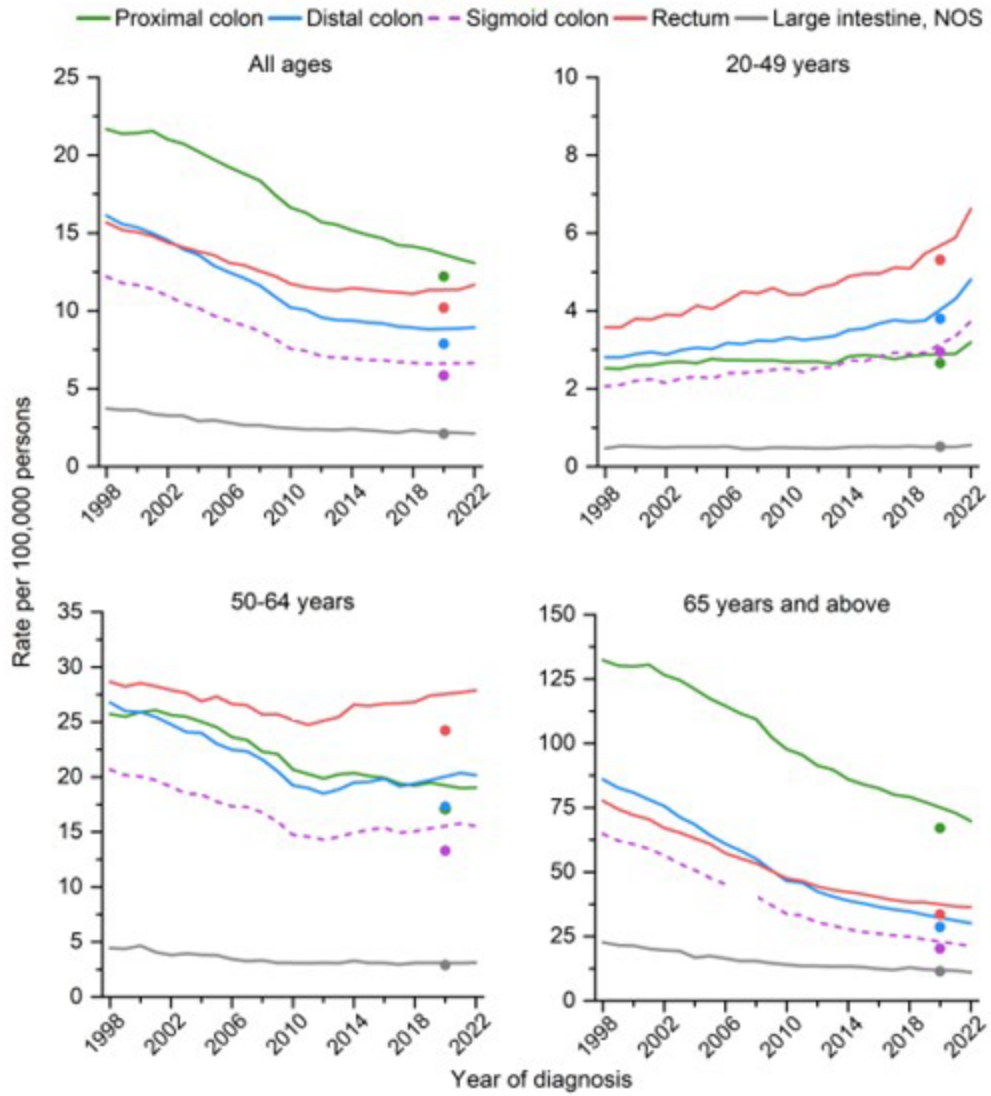
Trends in Colorectal Cancer Incidence by Age and Stage at Diagnosis, 1998–2022, US



Incidence rates exclude appendiceal cancer, are age-adjusted to the 2000 US standard population and adjusted for delays in case reporting. Incidence data for 2020 are shown separate from the trend lines.

Citation: Siegel RL, Wagle NS, Star J, Kratzer TB, Smith RA, Jemal A. Colorectal cancer statistics, 2026. CA Cancer J Clin. 2026;e70067. doi:10.3322/caac.70067

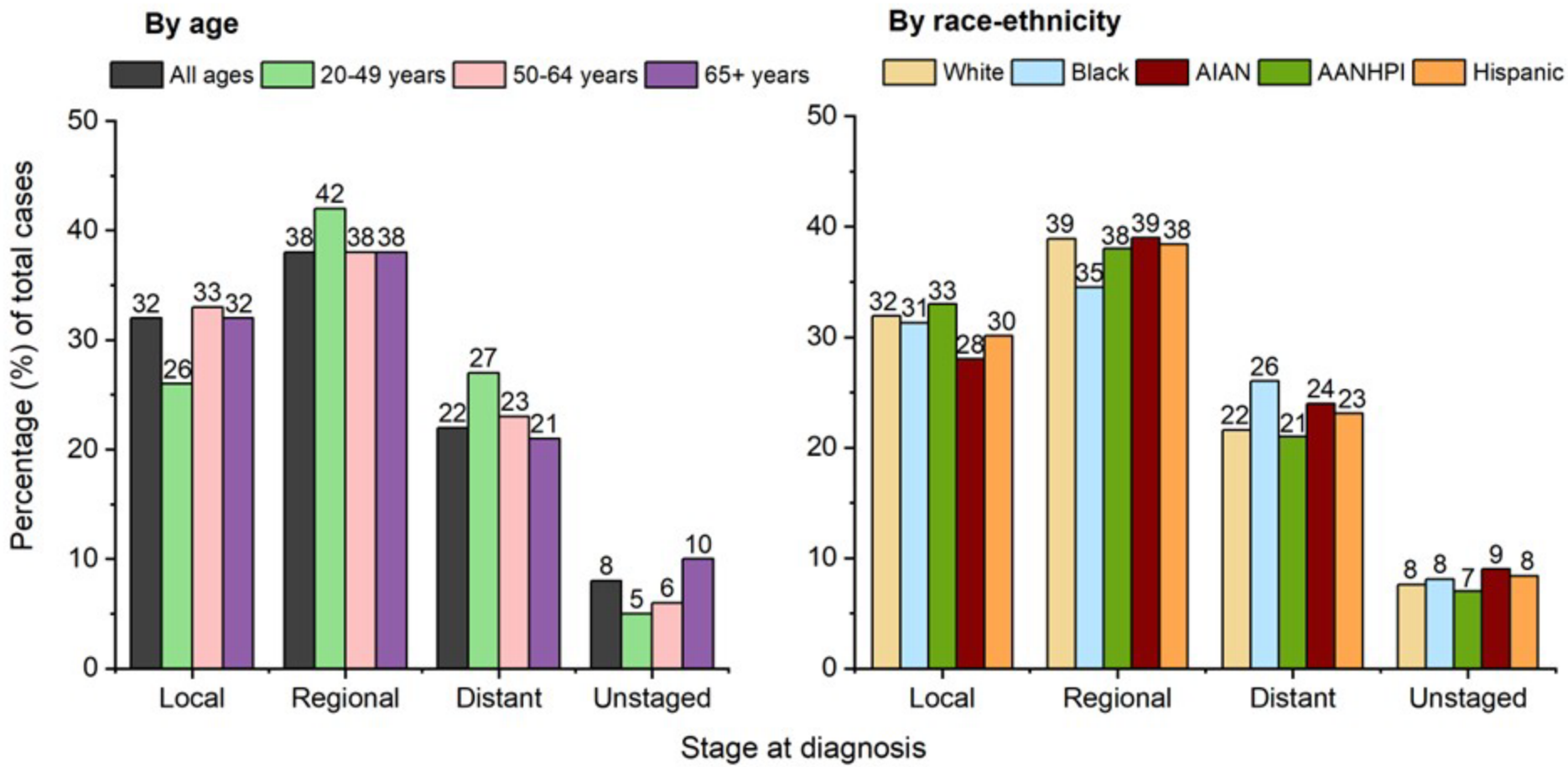
Trends in Colorectal Cancer Incidence by Age and Tumor Subsite, 1998-2022, US



Incidence rates exclude appendiceal cancer, are age-adjusted to the 2000 US standard population and adjusted for delays in case reporting. Incidence data for 2020 are shown separate from the trend lines. NOS, not otherwise specified.

Citation: Siegel RL, Wagle NS, Star J, Kratzer TB, Smith RA, Jemal A. Colorectal cancer statistics, 2026. CA Cancer J Clin. 2026;e70067. doi:10.3322/caac.70067

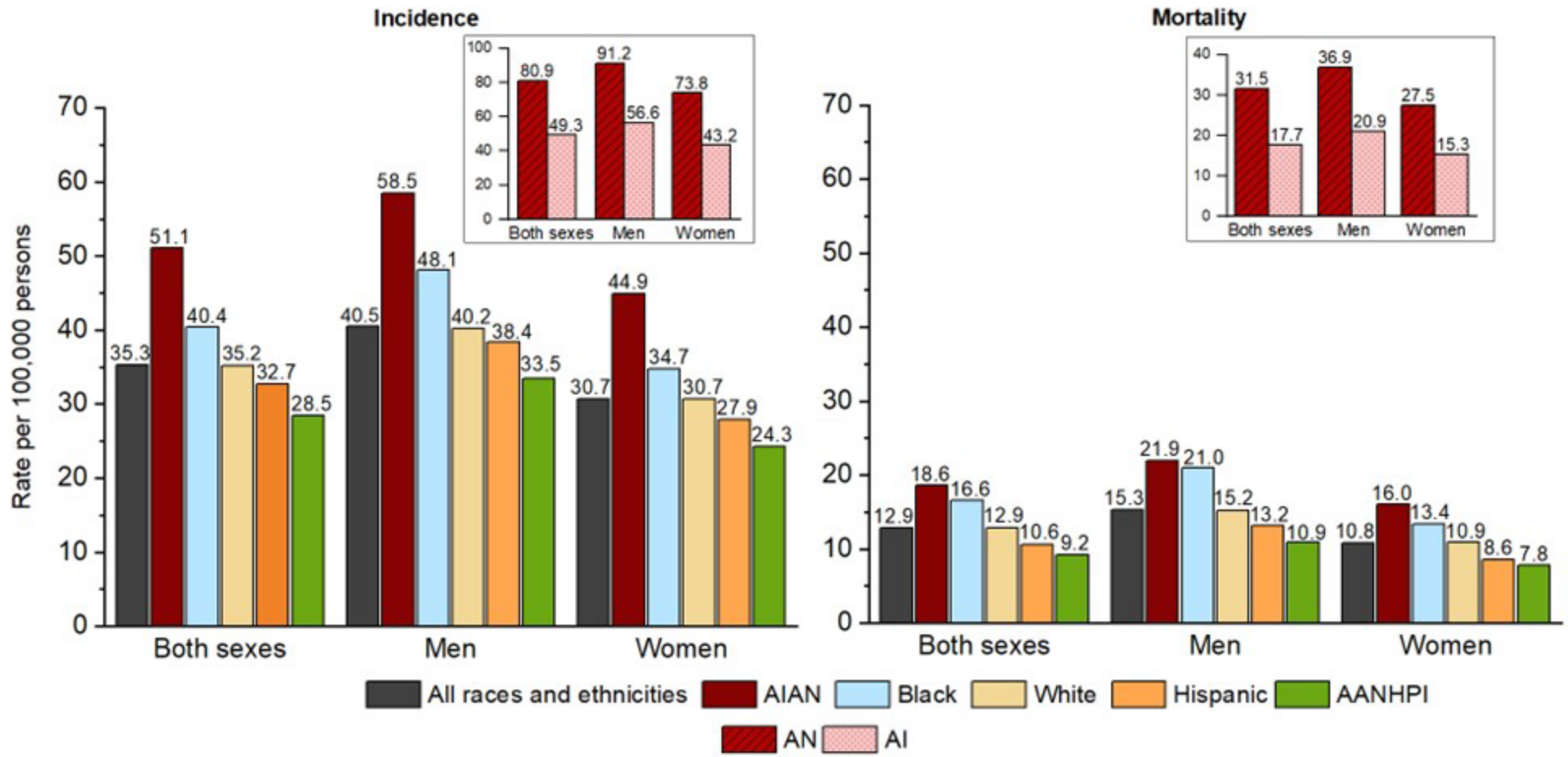
Colorectal Cancer Stage Distribution (%) by Age, Race, and Ethnicity, 2018–2022, US



Stage distribution excludes appendiceal cancer. Individual race categories are exclusive of Hispanic ethnicity. AANHPI, Asian American, Native Hawaiian, or other Pacific Islander; AI, American Indian; AN, Alaska Native.

Citation: Siegel RL, Wagle NS, Star J, Kratzer TB, Smith RA, Jemal A. Colorectal cancer statistics, 2026. CA Cancer J Clin. 2026;e70067. doi:10.3322/caac.70067

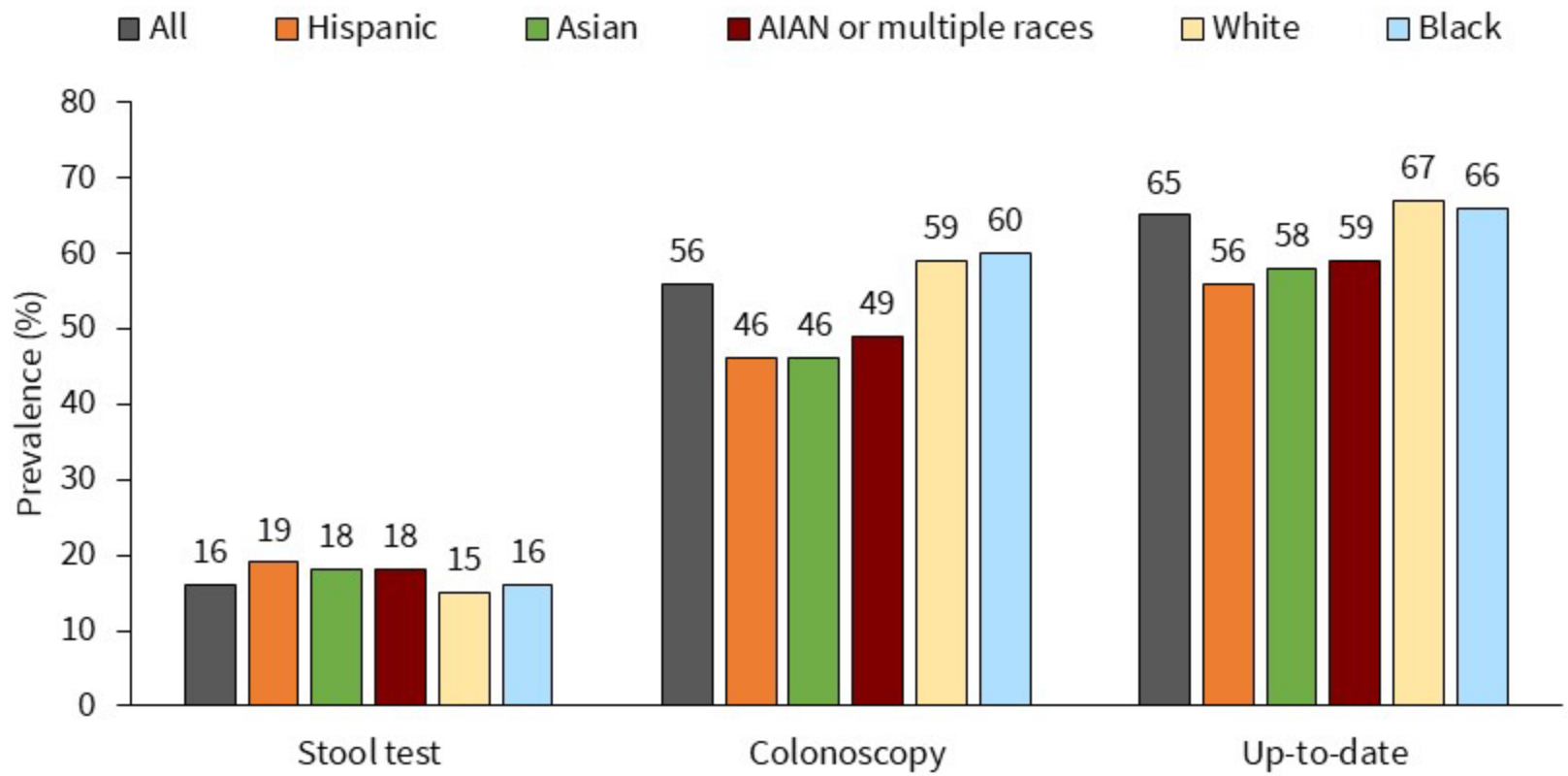
Colorectal Cancer Incidence (2018 To 2022) and Mortality (2019 To 2023) By Sex, Race, and Ethnicity, US



Incidence rates exclude appendiceal cancer and are adjusted for delays in case reporting. All rates are age-adjusted to the 2000 US standard population. AANHPI, Asian American, Native Hawaiian, or other Pacific Islander; AI, American Indian; AN, Alaska Native.

Citation: Siegel RL, Wagle NS, Star J, Kratzer TB, Smith RA, Jemal A. Colorectal cancer statistics, 2026. CA Cancer J Clin. 2026;e70067. doi:10.3322/caac.70067

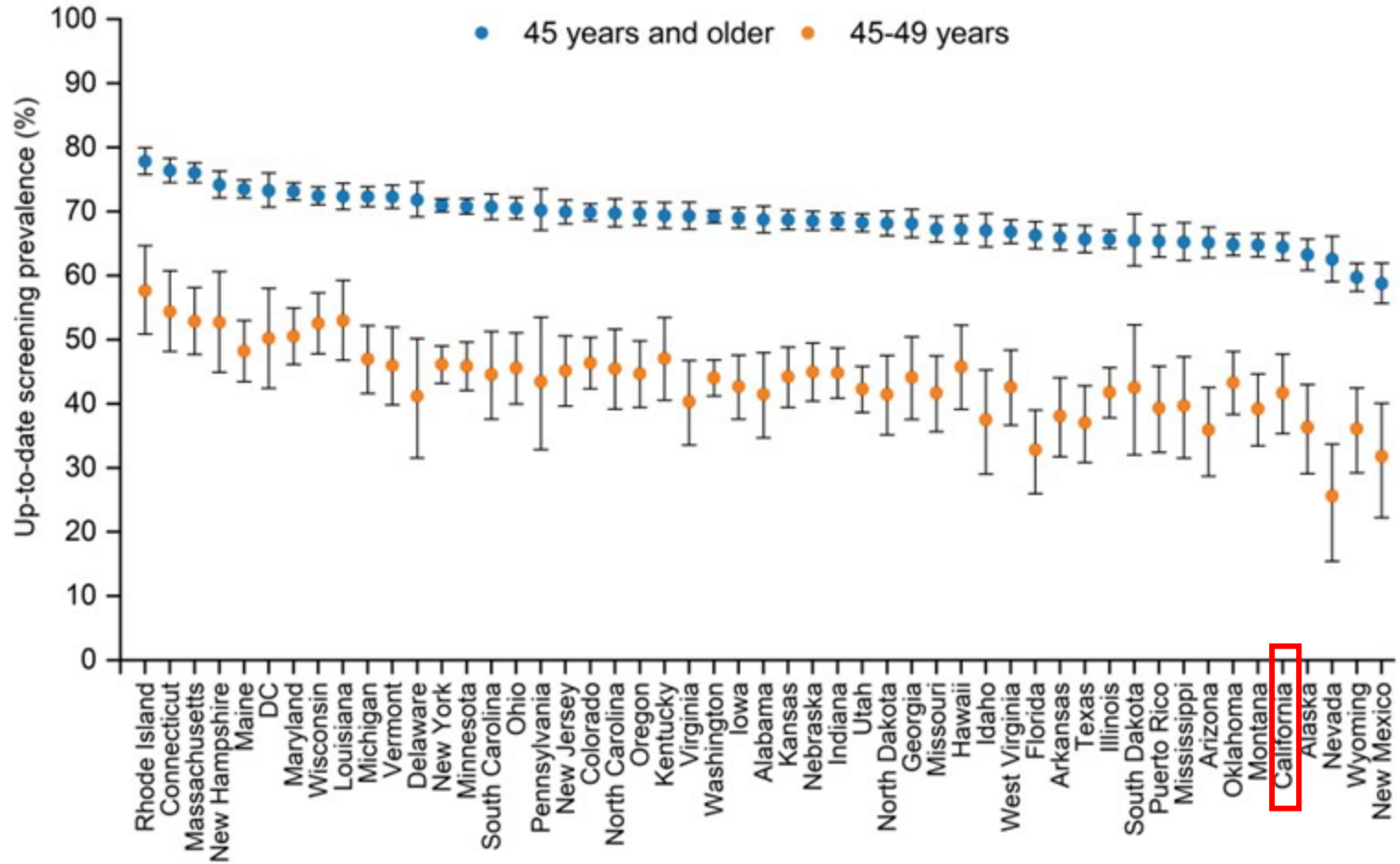
Up-to-date Colorectal Cancer Screening (%) by Race and Ethnicity, Ages 45 Years and Older, 2023, US



Estimates do not distinguish between examinations for screening and diagnosis. Stool test includes FOBT OR FIT within the past 1 year OR multi-target sDNA test within the past 3 years. Colonoscopy within the past 10 years. Up-to-date definition: For ages ≥45, 45-49, and 50-54: FOBT/FIT, sDNA, sigmoidoscopy, colonoscopy, or CT colonography, in the past 1, 3, 5, 10, and 5 years, respectively. For ages 45–75 years: FOBT/FIT, sDNA, sigmoidoscopy, colonoscopy, or CT colonography, in the past 1, 3, 5, 10, and 5 years, respectively, or sigmoidoscopy in the past 10 years with FOBT/FIT in the past 1 year. AI, American Indian; AN, Alaska Native.

Citation: Siegel RL, Wagle NS, Star J, Kratzer TB, Smith RA, Jemal A. Colorectal cancer statistics, 2026. CA Cancer J Clin. 2026;e70067. doi:10.3322/caac.70067

Up-to-date Colorectal Cancer Screening (%), Adults Aged 45 Years and Older by State, 2024, US



Tennessee was excluded for not meeting the minimum reporting requirements for the 2024 Behavioral Risk Factors Surveillance System. Up-to-date screening was defined as a fecal occult blood test/fecal immunochemical test, multi-target stool DNA test, sigmoidoscopy, colonoscopy, or computed tomography colonography, in the past 1, 3, 5, 10, and 5 years, respectively. Prevalence does not distinguish between screening and diagnostic examinations. Data for 45-years and older are age-adjusted to the 2000 US standard population.

Citation: Siegel RL, Wagle NS, Star J, Kratzer TB, Smith RA, Jemal A. Colorectal cancer statistics, 2026. CA Cancer J Clin. 2026;e70067. doi:10.3322/caac.70067

Medi-Cal Performance

California's CRC Screening Rates for Medi-Cal, FQHCs and OPA.GOV Commercial Health Plans' Rates

	2022	2023	2024
1. Kaiser North and South	69%	70%	72%
2. Sharp Health Plan	63%	67%	61%
3. Health Net HMO	58%	60%	63%
4. Anthem Blue Cross HMO	58%	62%	61%
5. Blue Shield California HMO	57%	60%	62%
6. FQHCs California	42%	42%	43%
Medi-Cal	**37%**	**40.46%**	**44.22%**

Medi-Cal is **38%** of California's Insured Population, Medicare rates are higher

https://reportcards.cdii.ca.gov/rc/HMO_PPO_combinedMeasure.aspx?Category=HMO_PPOHEDIS&Topic=PreventionCare&Measure=ColorectalCancerScreening FQHCS https://data.hrsa.gov.

California Compared to National Medicaid CRC Rates in 2024

CMS provides two CRC screening rates by age groups.

Age Range	National	California
46 to 50 year old	22.9%	24%
51 to 65 year old	37.7%	40.6%

California is in the second quartile nationally in both age ranges

https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures

Summary

- Medi-Cal colorectal cancer (CRC) screening rate exceeds national Medicaid colorectal cancer screening rate.
- Medi-Cal CRC screening rates have increased from 37% to 44% in just two years.
- Medi-Cal CRC screening rates are about 15% below California's commercially insured population's CRC screening rate.
- Medi-Cal CRC screening rates vary widely by health plan (HP) with several HPs screening only 33% their members who require screening. High performing HPs are screening between 51% to 78% of their members who require screening.
- In 2026, Medi-Cal health plans must exceed the national Medicaid HEDIS average to avoid DHCS sanctions

Screening Modalities

Screening Options: HEDIS/NCQA

- Colonoscopy q10 years
- Sigmoidoscopy q 5 years
- Fecal Immunochemical Tests
- Multi-Target Stool DNA (Cologuard Plus®)
- Multi-Target Stool RNA (Colosense®)
- Guardant Shield®
- Freenome SimpleScreen®

Why recommend FIT?

FIT vs Colonoscopy Participation Rates

Author	Intervention	Type of Test	FOBT adherence	Colonoscopy adherence	Choice
Quintero	RCT	FIT	34.2%	24.6%	n/a
Inadomi	Office invite	gFOBT	67%	38%	69% 38% FOBT/31% CLN
Gupta	Mailed	FIT	40.7%	24.6%	n/a

Quintero NEJM 2012;366:697-706

Inadomi. Arch Int Med 2012: 172(7): 575-582

Gupta, et al. *JAMA Intern Med*. 2013;173(18):1725-1732.

COLONPREV: Preliminary results after 1 round of FIT and 1-time colonoscopy

Table 1. Diagnostic Yield of Colonoscopy and Fecal Immunochemical Testing (FIT), According to the Intention-to-Screen Analysis.*

Colorectal Lesion	Colonoscopy (N = 26,703)		FIT (N = 26,599)		Odds Ratio (95% CI)†	P Value
	Subjects	Rate	Subjects	Rate		
	no.	%	*no.*	%		
Cancer	30	0.1	33	0.1	0.99 (0.61–1.64)	0.99
Advanced adenoma‡	514	1.9	231	0.9	2.30 (1.97–2.69)	<0.001
Advanced neoplasia§	544	2.0	264	1.0	2.14 (1.85–2.49)	<0.001
Nonadvanced adenoma	1109	4.2	119	0.4	9.80 (8.10–11.85)	<0.001
Any neoplasia	1653	6.2	383	1.4	4.67 (4.17–5.24)	<0.001

Quintero NEJM 2012;366:697-706

Once-only colonoscopy or two rounds of faecal immunochemical testing 2 years apart for colorectal cancer screening (SCREESCO): preliminary report of a randomised controlled trial

Intention To Screen Analysis

	Colonoscopy (N=31,400)	FIT (N=60,300)	Relative Risk
Participation	10,679 (35.1%)	33,383 (55.5%)*	NR
Cancer Detection	49 (0.16%)	121 (0.20%)	**0.78, 95% CI 0.56, 1.09**
Advanced Adenoma	637 (2.05%)	968 (1.61%)	**1.27, 95 % CI 1.15, 1.41**

*% of those received a FIT (N=60,137)

Forsberg et al Lancet Gastroenterol Hepatol 2022;7:513-521

Non-invasive screening tests

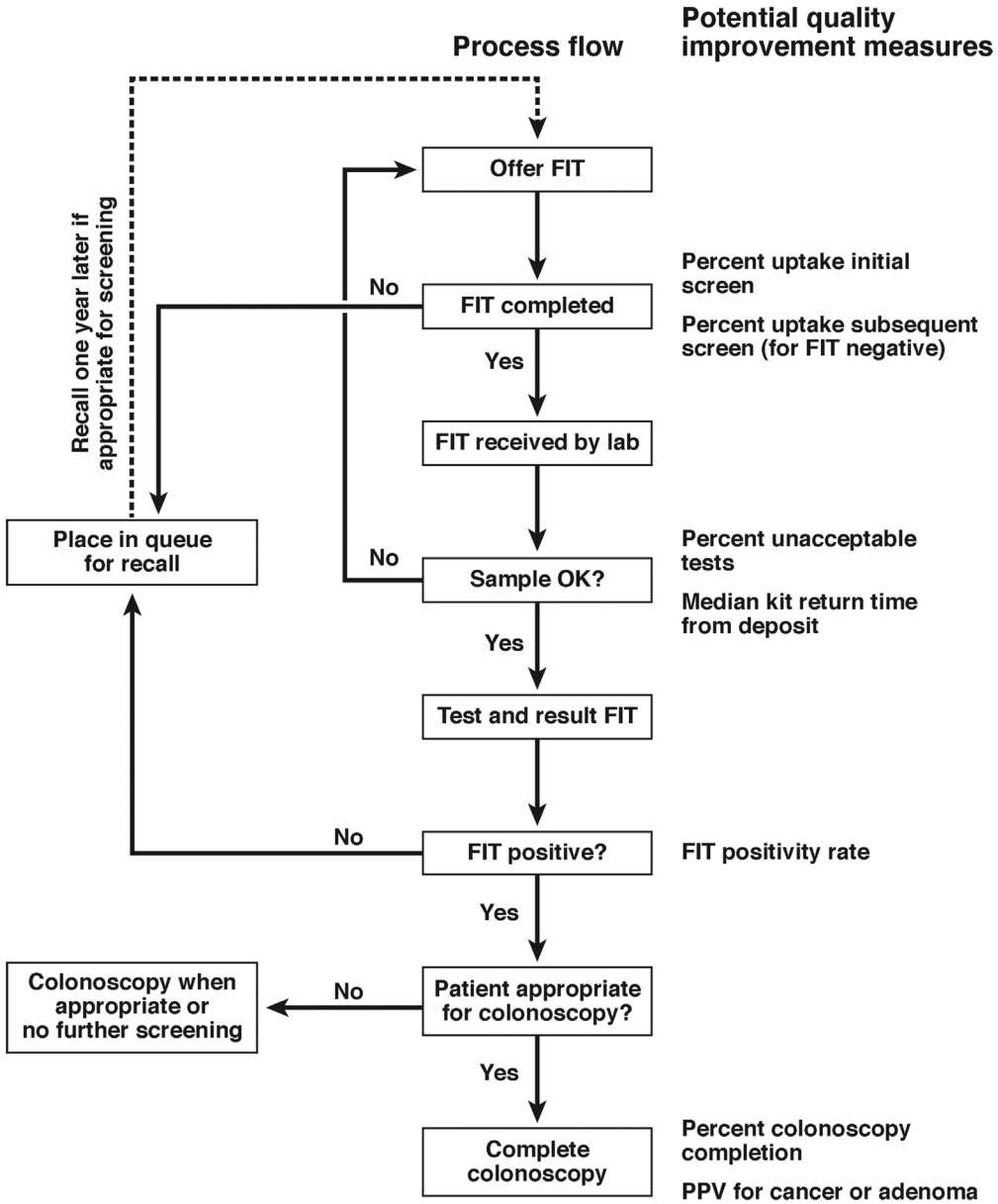
Test	Type of Test	Interval	Sensitivity for cancer	Sensitivity for APL	Specificity	FDA Approved
FIT[1]	Immunochemical Test for Human Hb	Annual	73.8%	23.8%	94.9%	Yes
Cologuard 1.0[1]	MTsDNA (+FIT)	3 years	92.3%	42.4%	86.6%	Yes
Cologuard Plus[2]	MTsDNA (+FIT)	3 years	93.9%	43.4%	90.6%	Yes
Colosense[3]	MTsRNA (+FIT)	3 years	94%	46%	88%	Yes
Shield[4] **Blood test**	Methylated cfDNA	3 years	83.1%	13.2%	89.6%	Yes
SimpleScreen[5] **Blood test**	Methylated cfDNA	?	79.2%	12.5%	91.5%	Yes
SimpleScreen 2.0*	Methylated cfDNA		80.4%	18.2%	90%	no

1. Imperiale. N Engl J Med. 2014
2. Imperiale N Engl J Med. 2024
3. Barnell JAMA. 2023
4. Chung N Engl J Med. 2024
5. Shaukat JAMA 2025

* Press Release

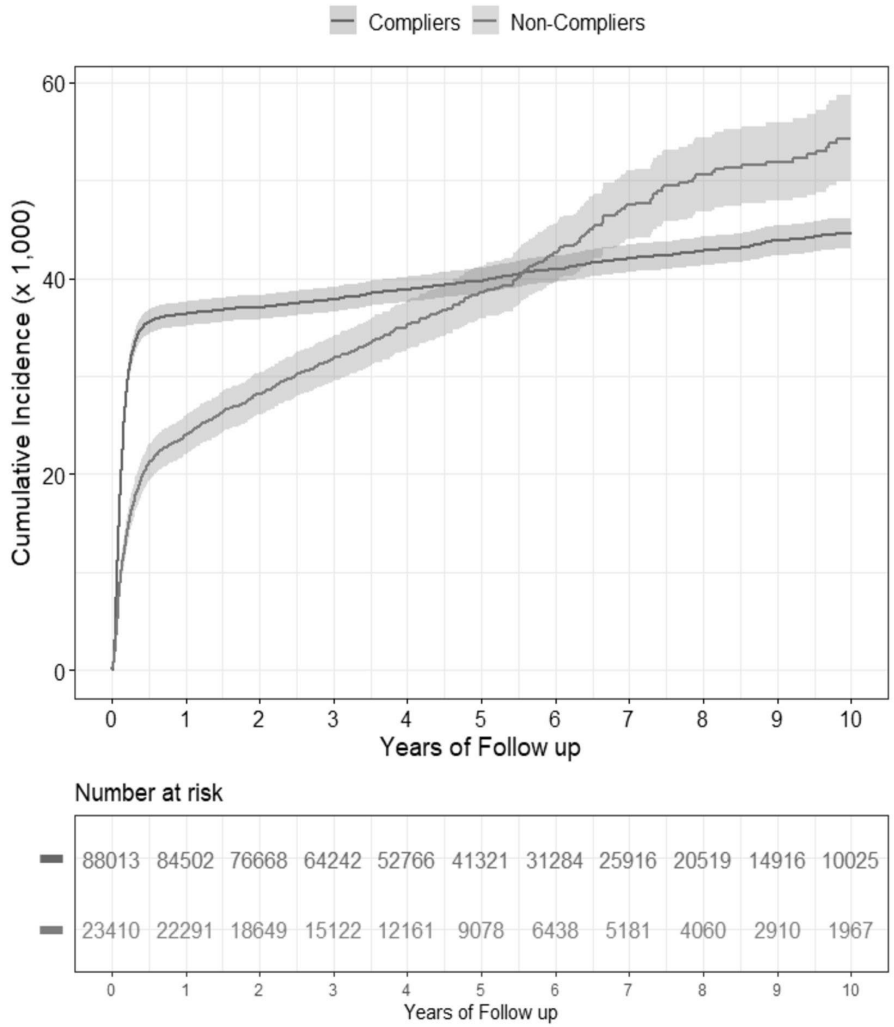
Non-Invasive Tests

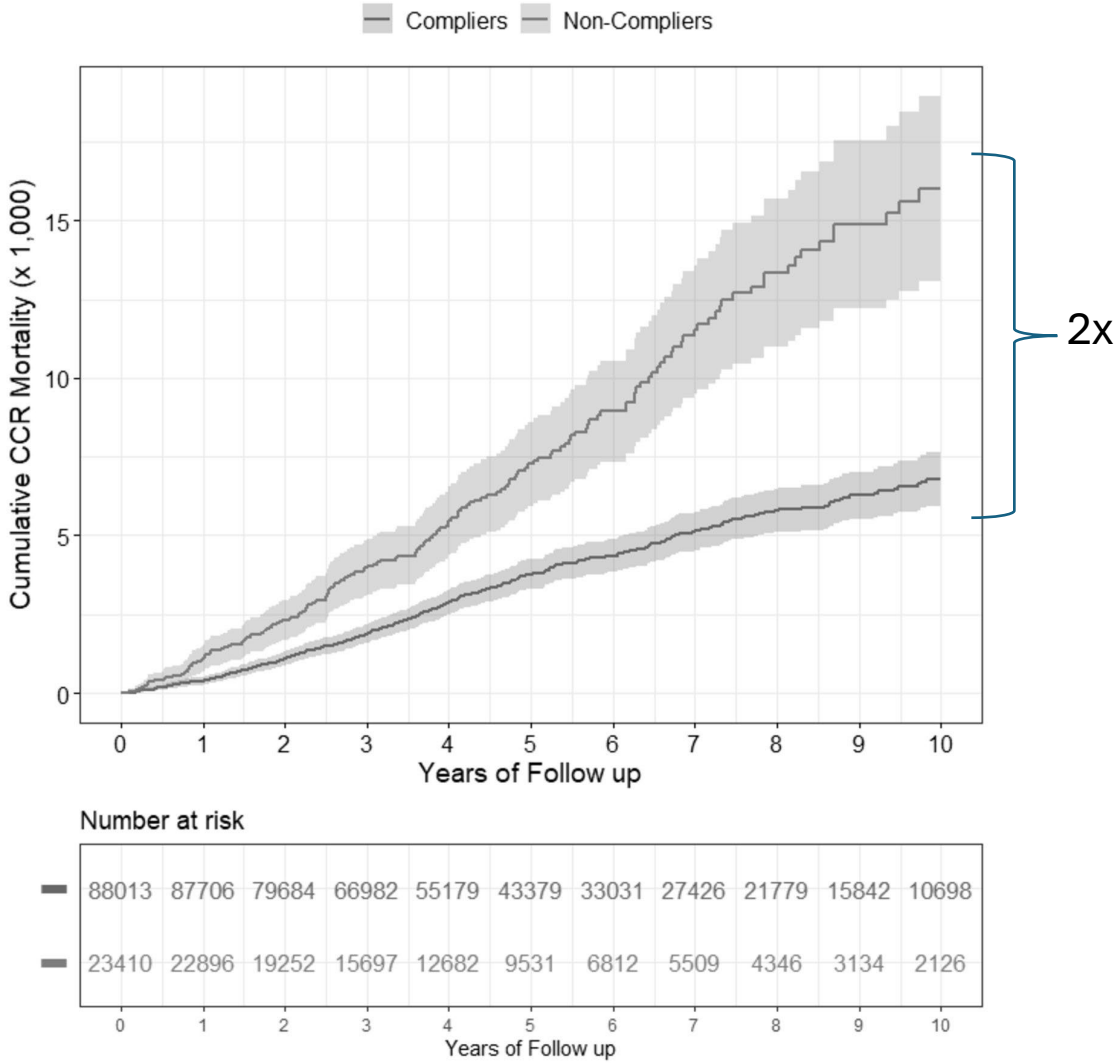
The Process of FIT Screening



Robertson Gastroenterology. 2017;152:1217-1237.e3. doi: 10.1053/j.gastro.2016.08.053.

Cancer Incidence and Mortality Associated with FIT+ follow up





Zorzi et al. Gut 2022;71:561-567

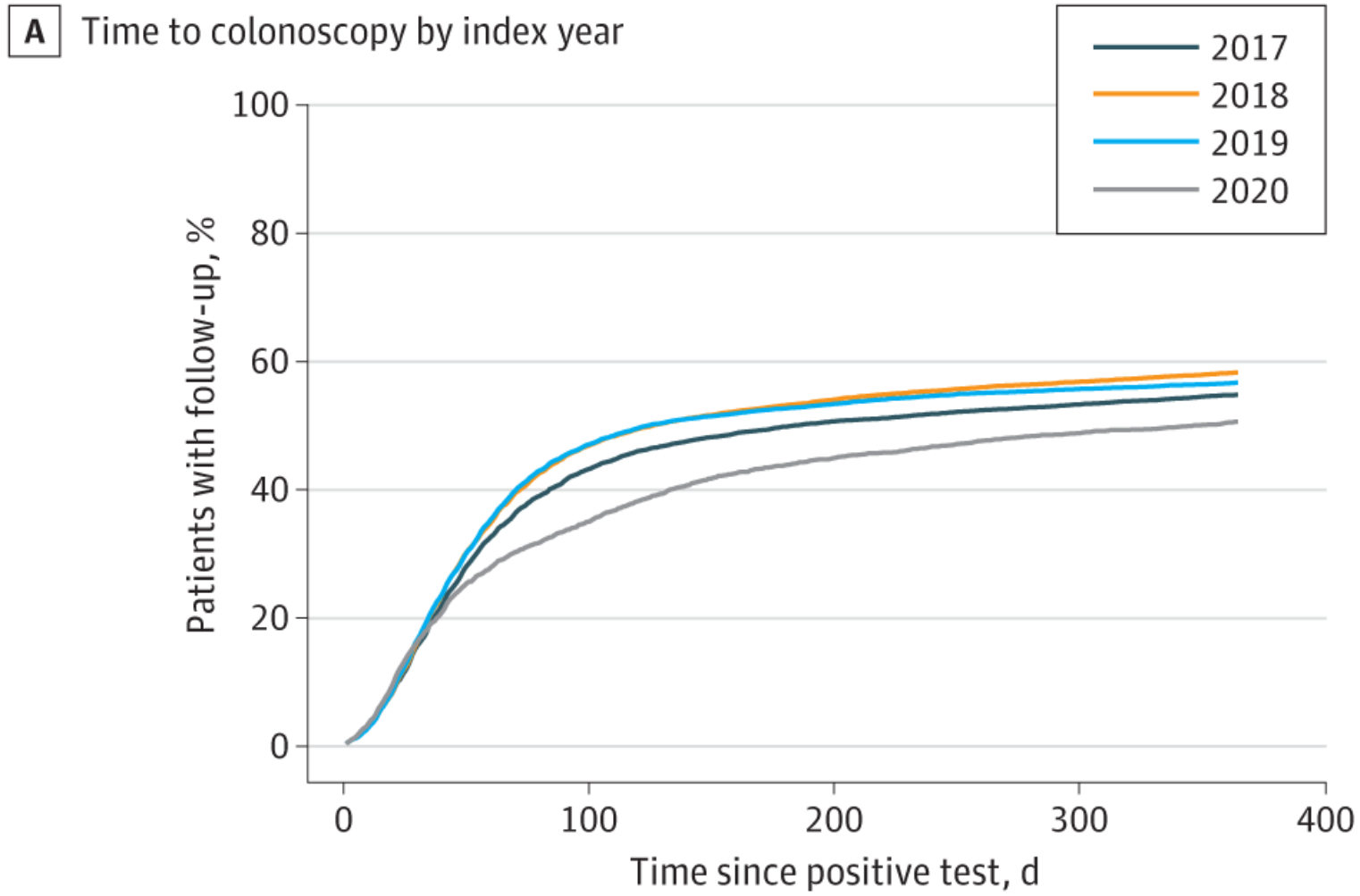
Time to follow up is important

Table 3. Time to Colonoscopy Among Patients Receiving a Positive FIT Result

Time to Colonoscopy[a]	Any Colorectal Cancer			Advanced-Stage Colorectal Cancer[b]		
	No. of Cases/ Total No.	Rate per 1000 Patients (95% CI)	Adjusted OR (95% CI)[c]	No. of Cases/ Total No.	Rate per 1000 Patients (95% CI)	Adjusted OR (95% CI)[c]
Comparison Group, 1-30 d						
1-30 d	871/28 567	30 (28-32)	1 [Reference]	248/28 564	9 (8-10)	1 [Reference]
2 mo	685/24 644	28 (26-30)	0.90 (0.81-0.99)	173/24 642	7 (6-8)	0.79 (0.65-0.97)
3 mo	265/8666	31 (27-34)	0.93 (0.80-1.07)	60/8664	7 (5-9)	0.73 (0.54-0.97)
4-6 mo	165/5251	31 (27-36)	0.95 (0.80-1.13)	46/5249	9 (6-11)	0.91 (0.66-1.25)
7-9 mo	58/1335	43 (32-54)	1.27 (0.96-1.67)	17/1335	13 (7-19)	1.22 (0.74-2.01)
10-12 mo	37/748	49 (34-65)	1.44 (1.02-2.02)	14/747	19 (9-28)	1.83 (1.06-3.17)
>12 mo	174/2304	76 (65-86)	2.19 (1.84-2.60)	72/2300	31 (24-38)	2.99 (2.27-3.93)
Comparison Group, 8-60 d						

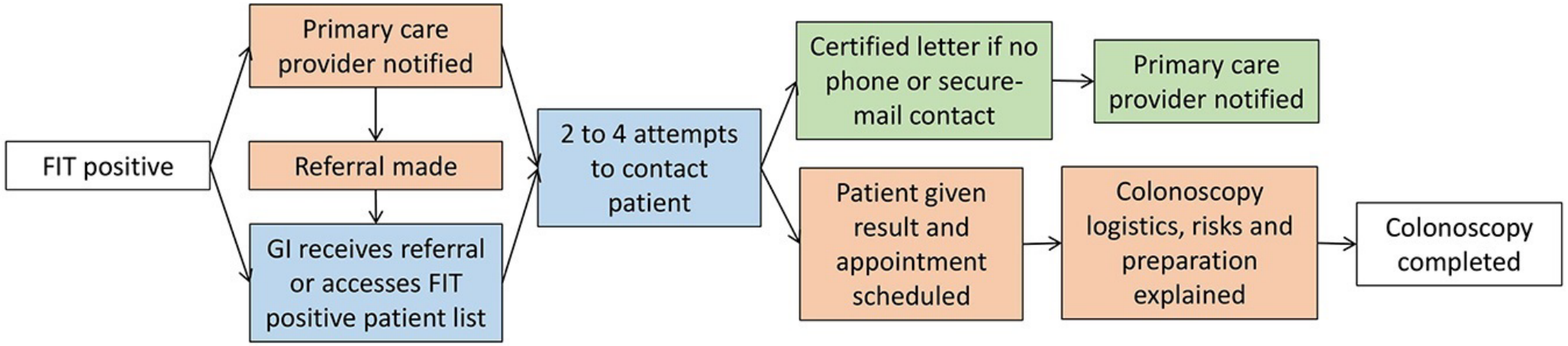
Corley DA, JAMA. 2017 doi: 10.1001/jama.2017.3634.

AMGA Data: 39 health plans



Mohl. JAMA Netw Open. 2023;6(1):e2251384.doi:10.1001/jamanetworkopen.2022.51384

Improving FIT follow up: KPNC



Implementation dates	
Existing	
2006-08	
2009-12	
2013-16	

Organizational supports

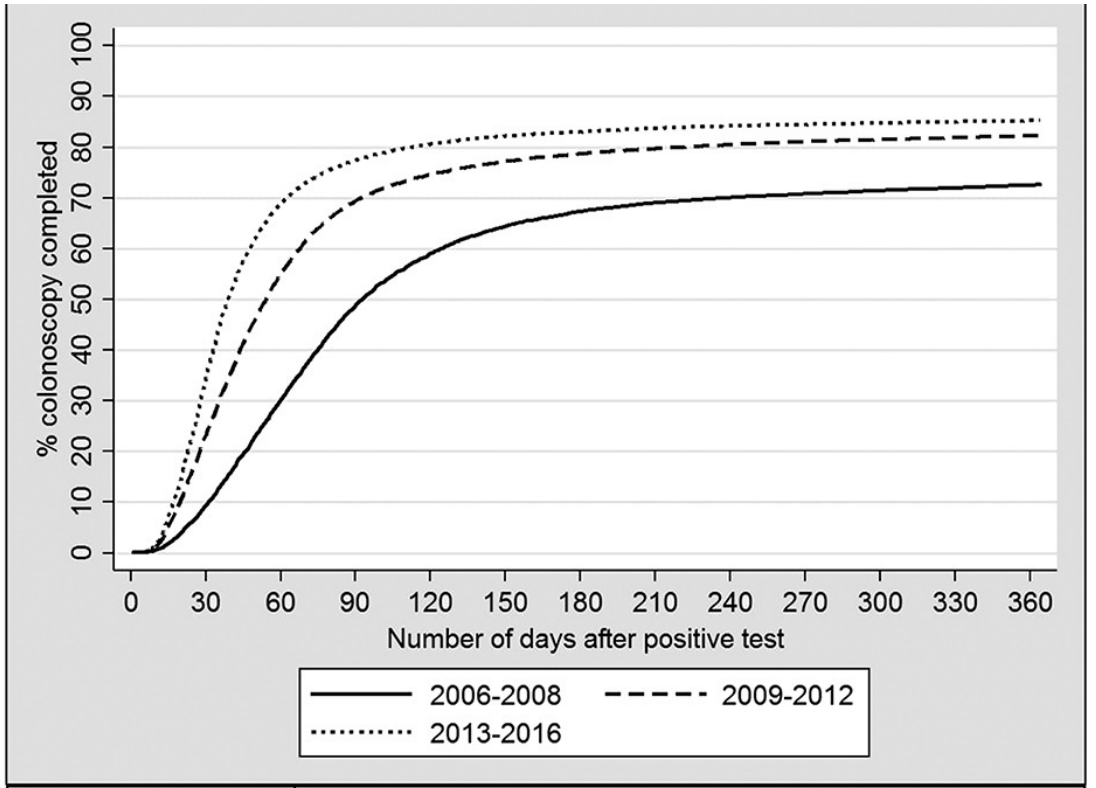
- Goal of colonoscopy follow-up within 30 days of positive result
- Adequate colonoscopy capacity (staff and endoscopy suites)
- Registry of FIT-positive patients with real-time updates
- Gastroenterology staff member designated responsible (NP, PA or MA)
- Financial reward to medical center for attaining colonoscopy access targets

Organizational supports

CLINICAL AND TRANSLATIONAL GASTROENTEROLOGY

Selby, Clin Transl Gastroenterol. 2019 Feb;10(2):e00010.

FIT follow up performance



	Percent with colonoscopy completed at each time point (95% confidence interval)				
Time Period	30 DAYS	60 DAYS	90 DAYS	180 DAYS	1 YEAR
2006 - 2008 (N=20,890)	9 (9-10)	30 (30-31)	49 (49-50)	67 (66-68)	73 (72-74)
2009 - 2012 (N=63,127)	23 (23-24)	55 (55-56)	69 (69-70)	79 (79-80)	82 (82-83)
2013 - 2016 (N=55,579)	34 (34-35)	69 (69-70)	77 (77-78)	83 (83-84)	85 (85-86)

CLINICAL AND TRANSLATIONAL GAS

The Health Plan Role

- ID unscreened populations using available data
- Implement population-level outreach
- Partner with providers to drive strategy (especially FQHCs)
- Support follow-up after abnormal tests

What Works?

- Organized screening where all eligible patients are invited for screening, regardless of whether they have a visit
- A recommendation from someone who is known and trusted:
  - Physicians, office based support staff
- Outreach using non-invasive tests to those not screened by colonoscopy: mailed, UPS, telehealth
- Patient Navigation, especially among marginalized communities
  - Unlicensed Staff: medical assistants, schedulers, community health workers, promotoras, lay health advisors
- Buy in from Gastroenterologists For Follow-up Colonoscopies

Evidence-Based Interventions for Colorectal Cancer Screening

EBIs are most successful when done together.



Patient Directed

- Reminders
- Education (one-on-one or group)
- Small Media



Provider Directed

- EHR Enhancements
- Assessment and feedback
- Standing orders
- Professional education
- Reminders and recall



Access to Care

- Reduce structural barriers
- Reduce out-of-pocket costs
- Patient Navigation & CHWs

Visit The Community Guide to learn more.

SOURCE: The Community Guide (Accessed May 2026)

https://thecommunityguide.org

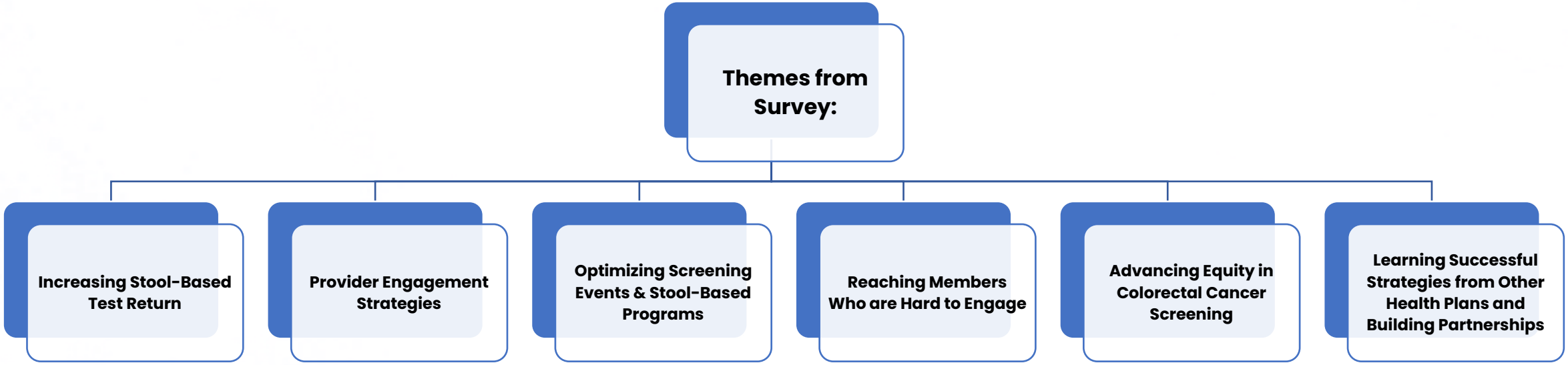
Take Home Messages

- We have improvement opportunities in California
- Health plan success is often linked to partnership with physicians and staff treating the patient
- Non-invasive testing is a great way to close care gaps
- Remember to follow up abnormal non-invasive tests

Questions?

Discussion Question

What are you hoping gain from participating in this collaborative?



American Cancer Society
California Colorectal Cancer Coalition
CDCC California Dialogue on Cancer

Resources

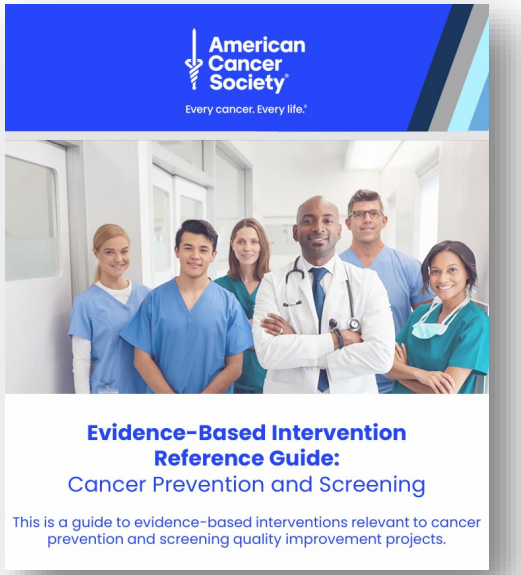
Evidence-Based Intervention Guide

Colorectal Cancer Screening Interventions

- 1:1 patient education
- Patient reminders/recall
- Small media
- Clinical champion/leadership buy-in
- EHR enhancements
- Professional education
- Provider reminders/recall
- Standing orders
- Engaging CHW's
- Patient navigation

Quality Improvement Implementation Manual

- Form a well-rounded team
- Assess baseline data
- Set a data-driven aim statement
- Create an action plan
- Explore processes and gaps to choose and test EBIs
- Track progress and celebrate success





American Cancer Society
California Colorectal Cancer Coalition
CDCC California Dialogue on Cancer

Resources

Colorectal Cancer

Screening guidelines for people at average risk

Ages 45–75	Ages 76–85	Over Age 85
Get screened. Several types of tests can be used. Talk to your healthcare provider about which option is best for you. **No matter which test you choose, the most important thing is to get screened regularly.**	**Talk to your healthcare provider.** They can help you decide whether to continue screening.	**No longer screen.** People over age 85 should no longer get colorectal cancer screening.

Testing Options

- **Visual exams** such as colonoscopy, CT colonography, and sigmoidoscopy look at the inside of the colon and rectum for polyps (growths) or cancer.
- **Stool-based tests** look for signs of cancer in stool and can be done at home. These tests include the fecal immunochemical test (FIT), guaiac-based fecal occult blood test (gFOBT), and multi-targeted stool DNA or RNA tests.
- **Blood-based tests** look for signs of cancer in a sample of blood. These are not preferred screening options at this time. They should only be used if a person is not willing to get a visual exam or stool-based test.
- All abnormal results on non-colonoscopy screening tests should be followed up with a timely colonoscopy.
- People with a family or personal history of polyps or colorectal cancer, or who have other risk factors, might need to start screening before age 45, be screened more often, or get specific tests.

Cancer screening saves lives. Get screened.

American Cancer Society

Colorectal Cancer Fact Sheet

for Patients and Caregivers



Colorectal cancer starts in either the colon or rectum. In the US, colorectal cancer is the third most common cancer. It is also the third-leading cause of cancer death in both men and women. Most colorectal cancers start with a polyp. A polyp is a small growth on the lining of the colon or rectum. Not all polyps develop into cancer.

Risk Factors

More than half of colorectal cancers can be linked to risk factors that can be changed. These include excess body weight, not being physically active, smoking, and alcohol. Risk can also be increased by eating a lo processed meats, or by not eating enough fruits, and whole grains.

There are other risk factors that can't be change include: your age; having a personal or family his colorectal polyps; having inflammatory bowel di certain hereditary syndromes (such as Lynch syn or type 2 diabetes; and your race and ethnicity. A American individuals and people of Ashkenazi Je are at higher risk for colorectal cancer.

If you have certain risk factors, your health care have you see a genetic counselor. They can help understand your risks and make informed decisi genetic testing and your care.

Prevention

Not all colorectal cancers can be prevented. But lower your risk.

- Get regular screening to help find problems th into cancer, such as polyps that can be remove
- Get to and stay at a healthy weight.
- Be as active as you can be.
- Eat a healthy diet with plenty of fruits, vegetables, and whole grains. Limit or avoid red and processed meats and highly processed foods.



If you're age 45 or older, you should start getting screened for colorectal cancer.

Colorectal cancer is one of the leading causes of cancer death in men and women, yet it can often be prevented or found at an early stage, when it's small and may be easier to treat, with regular screening.

Preventing colorectal cancer or finding it early doesn't have to be expensive. There are simple, affordable take-home tests available. Talk to your health care provider about which ones might be good options for you. No matter which test you choose, the most important thing is to get tested.

To learn more about colorectal cancer, visit the American Cancer Society website at **cancer.org** or call us at **1-800-227-2345**. We're here when you need us.

Click here to add a logo, or click the Remove button to clear the space.

Remove

7 Things to Know About Getting a Colonoscopy

Colorectal cancer screening is important because it can prevent cancer or find it early when it may be easier to treat. The American Cancer Society recommends colorectal cancer testing for everyone starting at age 45, though some people with certain risk factors may need to start at a younger age. Colonoscopy is one of the most common tests because not only can it find colon and rectal cancers, but it can also find polyps that can be removed before they turn into cancer. Knowing what to expect can take away some of the fear and anxiety of a colonoscopy and the preparation required for it. Here are 7 things to know before you go:



1 What is a colonoscopy?

A colonoscopy is an exam that lets a doctor closely look at the inside of the entire colon and rectum to find polyps or signs of cancer. Polyps are small growths that over time can become cancer. The doctor uses a flexible, hollow, lighted tube about the thickness of a finger that has a tiny video camera on the end. This tube, called a colonoscope, is gently eased inside the colon and sends pictures to a TV screen. Special instruments can be passed through the colonoscope to remove small polyps or take tissue samples if needed.



2 What is a bowel prep?

Bowel prep is a process to clean out the colon as much as possible so the doctor can see the inside clearly and get good pictures. The prep may include eating a special diet, drinking up to a gallon of a liquid laxative, medicines, and sometimes enemas that make you go to the bathroom a lot. You may also be instructed to stop taking certain over-the-counter or prescription medications up to a week before the test.

American Cancer Society cancer.org/coloncancer | 1.800.227.2345

American Cancer Society | California Colorectal Cancer Coalition | CDCC California Dialogue on Cancer

Resources

Colorectal cancer: Catch it early and reduce your risk.

American Cancer Society

Colorectal cancer is the third most common cancer in men and women in the US. Cancer screening tests look for cancer in people who don't have any signs or symptoms. When colorectal cancer is found early during screening, it's usually smaller and might be easier to treat.

US Colorectal Cancer Stats



While overall rates of colorectal cancer have gone down over the past 10 years, rates in people younger than age 50 have **gone up by about 2% each year.**

1 in 5
colorectal cancer cases are now in people under age 55.

1 in 3
people who get colorectal cancer have a family history. They're also more likely to get colorectal cancer at a earlier age.

1 in 5
people ages 45 through 49 are up-to-date on colorectal screening, lower than any other age group.

Who gets colorectal cancer?

Anyone can get colorectal cancer, but some people have a higher risk than others.



Certain health conditions increase risk.

- People with a personal or family history of colorectal cancer or polyps
- People with inflammatory bowel disease (ulcerative colitis and Crohn's)
- People with inherited gene changes, such as Lynch syndrome or familial adenomatous polyposis (FAP)
- People with type 2 diabetes



Certain communities are at higher risk.

- American Indian and Alaska Native people have the highest rates of colorectal cancer in the US.
- Black individuals have the second-highest rates of colorectal cancer and are most likely to be diagnosed later, when the cancer has spread to other parts of the body.
- Colorectal cancer rates are highest in West Virginia, Kentucky, Arkansas, Mississippi, and Louisiana.

cancer.org/colon | 1.800.227.2345

Can colorectal cancer be prevented?

Everyone should start regular screening for colorectal cancer at age 45.*

Stool-based tests



About stool-based tests

- Can be done at home
- Low cost
- No bowel prep or sedation
- Need to be done more often than visual tests
- Will need a colonoscopy if test is abnormal
- Can miss many polyps and some cancers

Stool-based test options

- Guaiac-based fecal occult blood test (gFOBT) **every year** or
- Fecal immunochemical Test (FIT) **every year** or
- Multi-targeted stool DNA test (MT-sDNA) **every 3 years**

Visual-exam tests



About visual-exam tests

- Done in doctor's office or health facility
- Bowel prep needed
- Only a colonoscopy can remove and test polyps
- Any test other than a colonoscopy will require a colonoscopy if the test is abnormal.

Visual exam test options

- Colonoscopy **every 10 years** or
- CT colonography (virtual colonoscopy) **every 5 years** or
- Flexible sigmoidoscopy **every 5 years**

*If you're at high risk of colorectal cancer based on family history or other factors, you may need to start screening before age 45, be screened more often, or get specific tests.

There are some differences between these tests to consider, but **the most important thing is to get screened, no matter which test you choose.**

More than half of all colorectal cancers are linked to physical inactivity, poor nutrition, excess body weight, tobacco, and alcohol.



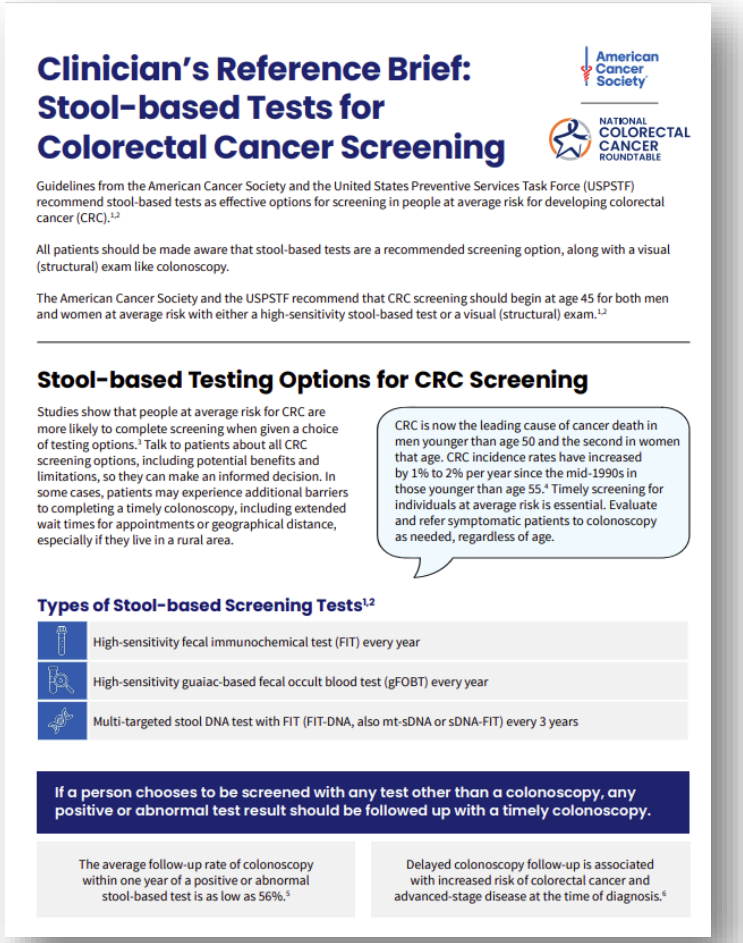
- Eat more vegetables, fruits, and whole grains.
- Limit or avoid red and processed meats, sugary drinks, and refined grains.
- Be as physically active as you can.
- Get to a healthy weight range.
- Don't use tobacco, and avoid secondhand smoke.
- Limit or avoid alcohol.

cancer.org/colon | 1.800.227.2345

©2023, American Cancer Society, Inc.
No. 012793 Rev. 12/23

American Cancer Society | California Colorectal Cancer Coalition | CDCC California Dialogue on Cancer

Resources



Clinician's Reference Brief: Stool-based Tests for Colorectal Cancer Screening

American Cancer Society

NATIONAL COLORECTAL CANCER ROUNDTABLE

Guidelines from the American Cancer Society and the United States Preventive Services Task Force (USPSTF) recommend stool-based tests as effective options for screening in people at average risk for developing colorectal cancer (CRC).[1,2]

All patients should be made aware that stool-based tests are a recommended screening option, along with a visual (structural) exam like colonoscopy.

The American Cancer Society and the USPSTF recommend that CRC screening should begin at age 45 for both men and women at average risk with either a high-sensitivity stool-based test or a visual (structural) exam.[1,2]

Stool-based Testing Options for CRC Screening

Studies show that people at average risk for CRC are more likely to complete screening when given a choice of testing options.[3] Talk to patients about all CRC screening options, including potential benefits and limitations, so they can make an informed decision. In some cases, patients may experience additional barriers to completing a timely colonoscopy, including extended wait times for appointments or geographical distance, especially if they live in a rural area.

CRC is now the leading cause of cancer death in men younger than age 50 and the second in women that age. CRC incidence rates have increased by 1% to 2% per year since the mid-1990s in those younger than age 55.[4] Timely screening for individuals at average risk is essential. Evaluate and refer symptomatic patients to colonoscopy as needed, regardless of age.

Types of Stool-based Screening Tests[1,2]

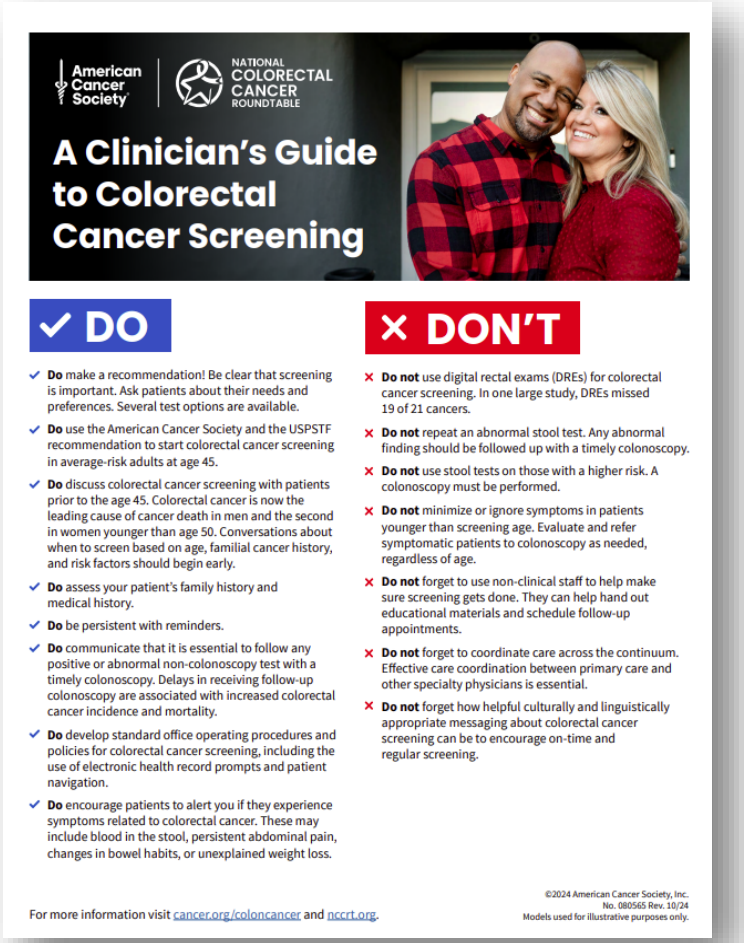
- High-sensitivity fecal immunochemical test (FIT) every year
- High-sensitivity guaiac-based fecal occult blood test (gFOBT) every year
- Multi-targeted stool DNA test with FIT (FIT-DNA, also mt-sDNA or sDNA-FIT) every 3 years

If a person chooses to be screened with any test other than a colonoscopy, any positive or abnormal test result should be followed up with a timely colonoscopy.

The average follow-up rate of colonoscopy within one year of a positive or abnormal stool-based test is as low as 56%.[5]

Delayed colonoscopy follow-up is associated with increased risk of colorectal cancer and advanced-stage disease at the time of diagnosis.[6]

[Clinician's Reference – Stool Based Tests for Colorectal Cancer Screening Brief]



American Cancer Society | NATIONAL COLORECTAL CANCER ROUNDTABLE

A Clinician's Guide to Colorectal Cancer Screening

✓ DO

- **Do** make a recommendation! Be clear that screening is important. Ask patients about their needs and preferences. Several test options are available.
- **Do** use the American Cancer Society and the USPSTF recommendation to start colorectal cancer screening in average-risk adults at age 45.
- **Do** discuss colorectal cancer screening with patients prior to the age 45. Colorectal cancer is now the leading cause of cancer death in men and the second in women younger than age 50. Conversations about when to screen based on age, familial cancer history, and risk factors should begin early.
- **Do** assess your patient's family history and medical history.
- **Do** be persistent with reminders.
- **Do** communicate that it is essential to follow any positive or abnormal non-colonoscopy test with a timely colonoscopy. Delays in receiving follow-up colonoscopy are associated with increased colorectal cancer incidence and mortality.
- **Do** develop standard office operating procedures and policies for colorectal cancer screening, including the use of electronic health record prompts and patient navigation.
- **Do** encourage patients to alert you if they experience symptoms related to colorectal cancer. These may include blood in the stool, persistent abdominal pain, changes in bowel habits, or unexplained weight loss.

× DON'T

- **Do not** use digital rectal exams (DREs) for colorectal cancer screening. In one large study, DREs missed 19 of 21 cancers.
- **Do not** repeat an abnormal stool test. Any abnormal finding should be followed up with a timely colonoscopy.
- **Do not** use stool tests on those with a higher risk. A colonoscopy must be performed.
- **Do not** minimize or ignore symptoms in patients younger than screening age. Evaluate and refer symptomatic patients to colonoscopy as needed, regardless of age.
- **Do not** forget to use non-clinical staff to help make sure screening gets done. They can help hand out educational materials and schedule follow-up appointments.
- **Do not** forget to coordinate care across the continuum. Effective care coordination between primary care and other specialty physicians is essential.
- **Do not** forget how helpful culturally and linguistically appropriate messaging about colorectal cancer screening can be to encourage on-time and regular screening.

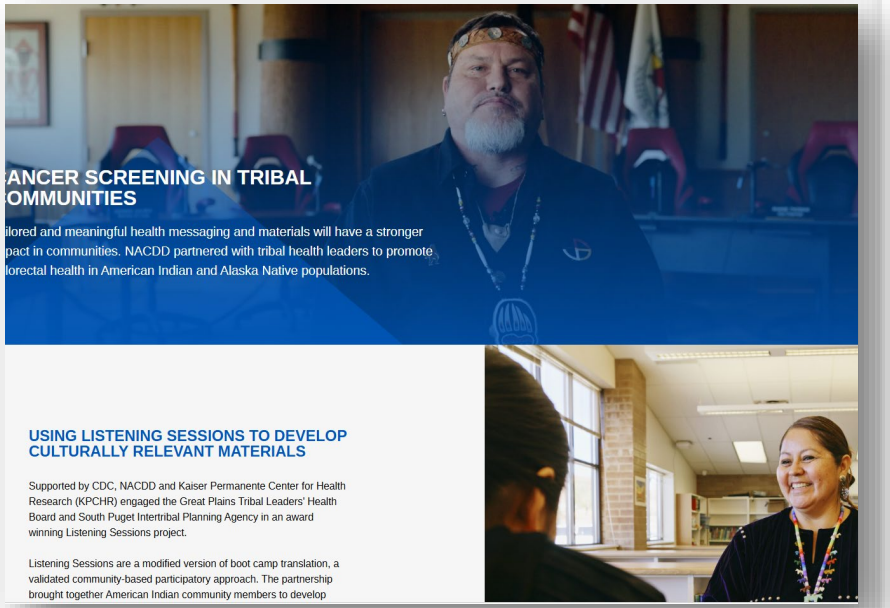
For more information visit cancer.org/coloncancer and nccrt.org.

©2024 American Cancer Society, Inc.
No. 080565 Rev. 10/24
Models used for illustrative purposes only.

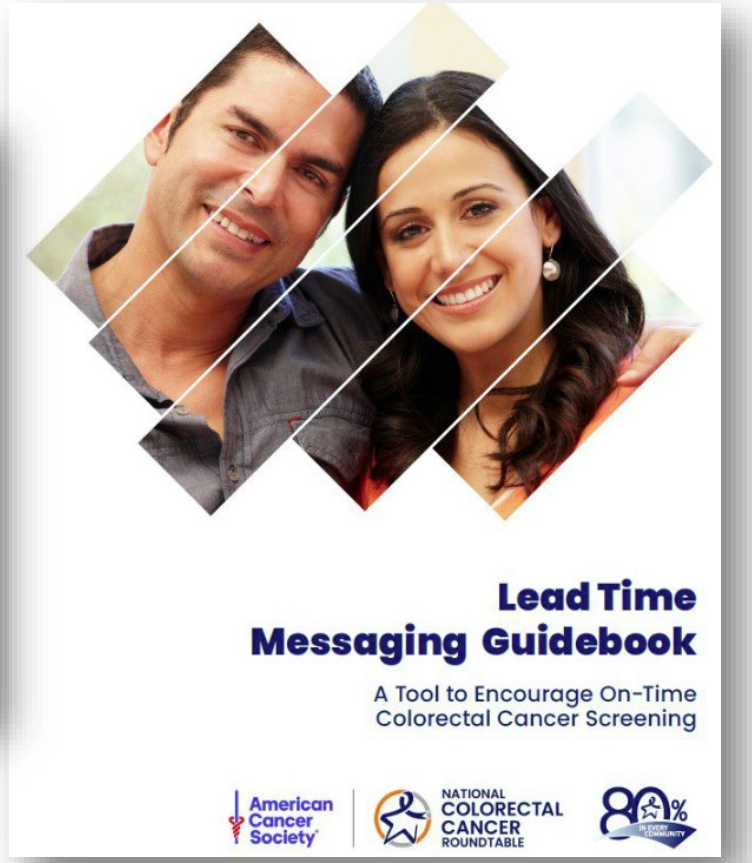
[The Dos and Don'ts of Colorectal Cancer Screening]

American Cancer Society | California Colorectal Cancer Coalition | CDCC California Dialogue on Cancer

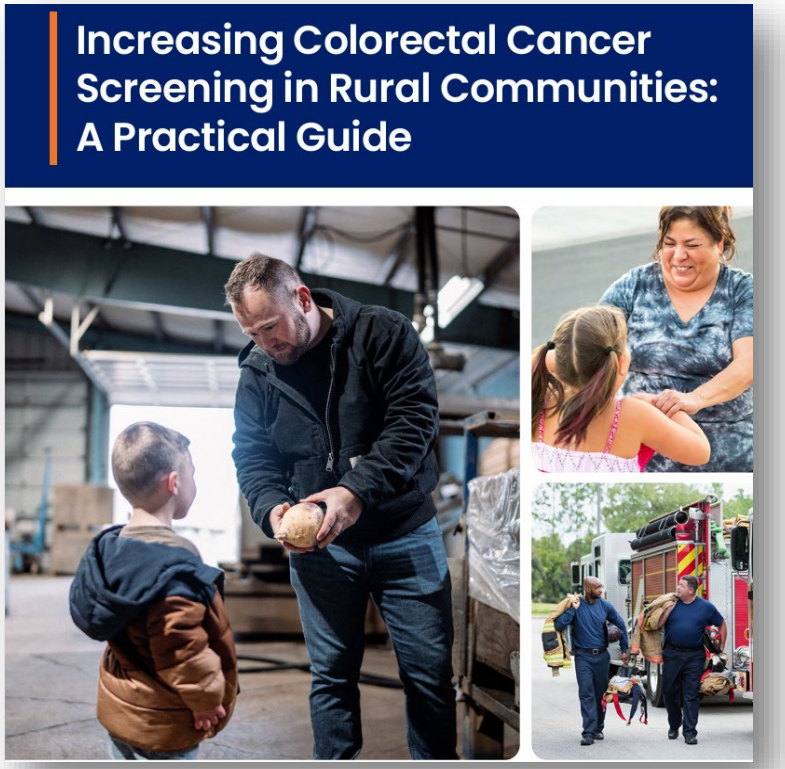
Resources



[Cancer Screening in Tribal Communities Listening Session Guide]



[Lead Time Messaging Guidebook]



[Increasing Colorectal Cancer Screening in Rural Communities: A Practical Guide]

American Cancer Society
California Colorectal Cancer Coalition
CDCC California Dialogue on Cancer

Colorectal Cancer Screening Resource Hub

Newly Launched! [Colorectal Cancer Screening Resources – California Colorectal Cancer Coalition (C4)]

California Health Plan Colorectal Cancer Screening Learning Collaborative – Resource Hub

The American Cancer Society (ACS), the California Colorectal Cancer Coalition (C4), and the California Dialogue on Cancer (CDOC) are piloting a statewide Learning Collaborative designed to support California health plans in improving colorectal cancer screening rates among their enrolled populations.

As part of this initiative, we have created this Resource Hub to support participating health plans with their colorectal cancer screening education, outreach, and engagement efforts for providers, members, patients, and communities across California. For more information about this initiative, please contact shauntay.davis@cdph.ca.gov.

We intend to add resources to this landing page throughout the learning collaborative. We hope these resources help to advance your colorectal cancer screening initiatives and improve health outcomes for the populations you serve.

Learning Collaborative Sessions – Recordings and Resources

Session Date & Time	Title of Session	Link to Recording and Slides
August 25, 2026, Noon–1PM PST	Learning Collaborative Kickoff: Advancing Colorectal Cancer Screening Through Health Plan Leadership	TBD
September 24, 2026, 12–1PM PST	From Fragmented Data to Action: Using Data to Improve CRC Screening	TBD
October 2026 (Date & Time TBD)	Population-Based Screening Strategies: Mailed Outreach at Scale (FIT and FIT-DNA)	TBD
January 2027 (Date & Time TBD)	Member Engagement Strategies to Drive Screening Uptake	TBD
February 2027 (Date & Time TBD)	Provider Interventions & Engagement – What Plans Can Do to Influence Providers	TBD
March 2027 (Date & Time TBD)	From Positive Test to Colonoscopy: Closing the Loop on CRC Screening	TBD
April 2027 (Date & Time TBD)	TBD	TBD

Colorectal Cancer Screening Resources

- Health Professionals +
- Systems Interventions & Program Planning +
- Quality Improvement Resources +
- Members, Patients, and Community Members +
- Data Resources +
- American Cancer Society Patient Support Programs and Services +

Colorectal Cancer Screening Resources

Health Professionals −

- NCCRT – National Colorectal Cancer Roundtable: National coalition providing evidence-based tools, best practices, and resources to increase colorectal cancer screening rates.
- American Cancer Society Guidelines for Colorectal Cancer Screening: Website with current screening recommendations, eligibility criteria, screening methods, and screening intervals.
- Colorectal Cancer Fact Sheet for Health Care Professionals: Quick-reference overview of colorectal cancer burden, screening tests, risk factors, treatment options and key statistics.
- The Dos and Don'ts of Colorectal Cancer Screening: One-page flyer about some of the dos and don'ts for colorectal cancer screening.
- Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Primary Care Practices: Step-by-step guide for implementing evidence-based interventions to improve colorectal cancer screening and follow-up rates in primary care settings.
- Colorectal Cancer 101 PowerPoint: Ready-to-use presentation with talking points that provides an overview of colorectal cancer prevention, screening, and early detection.

Systems Interventions & Program Planning +

Quality Improvement Resources +

Next Steps

- **QI leads: Baseline survey due September 15th**

- **Next two learning collaborative sessions: September 24th and October 29th** (calendar invitations coming tomorrow)
  - *Want to invite additional colleagues? Please invite them to register here: https://forms.office.com/g/rDbvKVH4E3*

- **Interested in individual technical assistance from ACS, C4, and CDOC?** Please email shauntay.davis@cdph.ca.gov

American Cancer Society
California Colorectal Cancer Coalition
CDOC California Dialogue on Cancer

Session #2:
September 24th 12pm-1pm PST

From Fragmented Data to Action: Using Data to Improve CRC Screening

Brenna Lin, PhD
National Committee for Quality Assurance
California Colorectal Cancer Coalition Board of Directors



In person registration closes September 18
Virtual registration is available
https://www.cacoloncancer.org/wc4/

Thank you for joining us!

Please complete our session evaluation:

California Health Plan Colorectal Cancer Screening Learning Collaborative Evaluation