

**MALIGNANT
POLYP**

CROHN'S

Crohn's disease is an inflammatory bowel disease (IBD). It causes inflammation of the lining of your digestive tract and increases your risk of colorectal cancer.

**ADVANCED COLON
CANCER**

BOTTOMS UP INVITATIONAL 2026

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Welcome & Introductions



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CEO, COLORECTAL CANCER ALLIANCE

MICHAEL SAPIENZA

SCREEN SMART 2026

Agenda

Welcome & Opening Remarks

Industry Leadership Panel

Personal Story & CRC Connection

Closing Remarks

**Understanding the 2026 ACS CRC
Screening Guidelines**

Reception

Expert Commentary



DIRECTOR OF PREVENTION AND PARTNERSHIP LEAD
DIONNE CHRISTOPHER



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A FRAMEWORK UPDATE

COLORECTAL CANCER SCREENING OPTIONS



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SCREEN SMART 2026

Updates from Manufacturers

Abbott Cancer Diagnostics

- March 2026: Model-based evaluation of colorectal cancer screening effectiveness: three rounds of multitarget stool DNA testing versus one colonoscopy
- June 2026: Multitarget Stool DNA Versus Fecal Immunochemical Testing: A National Assessment of Follow-Up Colonoscopy by Race and Ethnicity

Guardant Health

- March 2026: Shield test becomes accessible for physicians to order through partnership with Quest Diagnostics
- July 2026: UnitedHealthcare covers Shield Blood Test for eligible members aged 45+

Sensitivity	Colonoscopy	CTC	FIT	Cologuard		Cologuard Plus	ColoSense	Shield	PREEMPT CRC
	Recommended by the USPSTF & ACS					Emerging Tests			
Test Type	Visual (endoscopy)	Computed tomography	Hemoglobin in stool	Mt-sDNA		Mt-sDNA	Mt-sRNA	Cell-free DNA blood test	Blood
CRC overall	95%	86-100% Size of adenomas >6mm: 89% >7mm: 91% >8mm: 94% >9mm: 93% >10mm: 94%	79%	92%		94%	94.40%	83%	81.10%
Stage I	75-80%		75%	90%		87%	100%	65%(55% clinical)	63.50%
Stage II	85-90%		88%	100%		94%	83%	100%	100%
Stage III	85-90%		82%	90%		97%	100%	100%	80.50%
Stage IV	>95%		89%	75%		100%	100%	100%	100%
APL/AA	90-95%	89% for adenomas ≥10 mm	24% (APL)	42% (APL)		43% (APL)	46% (AA)	13.20%	13.7% (AA)
High grade dysplasia	75-93%	<10%	-	69%		75%	65% (HGD or ≥10 adenomas)	226%	29%
Sessile serrated	70-80%	-	5%	42%		46%	17% (hyperplastic and SS ≥10)	11% in SSL's greater than 1cm	-

	Specificity	All	Negative Colonoscopy
Recommended by the USPSTF & ACS	Colonoscopy	90%	–
	CTC	94% Size of adenomas	–
	FIT	93%	–
	Cologuard	87%	93%
Recommended by ACS	Cologuard Plus	94%	93%
	ColoSense	86%	88%
	Shield	89.6% (negative advanced neoplasia)	89.9% (non-neoplastic findings and negative colonoscopy)
	PREEMPT CTC	91.5% (non-advanced colorectal neoplasia)	–

		Access	Cost
Recommended by the USPSTF & ACS	Colonoscopy	Medicare	\$2,750 (avg. cash price)
	CTC	Medicare	\$265 per screening year
	FIT	Widely available/covered	\$18 – \$21 estimation of \$153 per screening cycle when including the patient support costs
	Cologuard	Widely available/covered	\$508 (Medicare)
Emerging Tests	Cologuard Plus	Not currently available	\$592 (Medicare)
	ColoSense	Not currently guideline-recommended but is FDA- approved to screen for colorectal cancer, advanced adenomas, and sessile serrated lesions, in average-risk individuals over the age of 45	\$508 (Medicare)
	Shield	Available under the CRC screening National Coverage Determinations (NCDs) Current Coverage through Medicare and VA CCN	\$1495 (Medicare)
	PREEMT CRC	Not currently available	–

		Adherence (%)		Follow-up colonoscopy	Interval
Recommended by the USPSTF & ACS	Colonoscopy	About 30%	Real World Data N=	n/a	10
	CTC	30–34%	Real World Data N=	-	5
	FIT	35% (w/o navigation) 41.5% (w navigation) (real-world and study)	Real World Data N=	47% - 83%	1
	Cologuard	71%	Real World Data N= 1,557,915	71.5% – 84.9% (real-world)	3 (1-3)
Emerging Tests	Cologuard Plus			–	3 (anticipated)
	ColoSense	78%	Study N=14,263	88% 74% combined test and follow up (study)	3 (anticipated)
	Shield	96%	Study N= 10,000	49% (within 6 months of positive results (real- world))	1-3 years
	PREEMT CRC	96%	Study N=	–	3



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PERSONAL STORY & CRC CONNECTION



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CO-ANCHOR, TODAY SHOW, CO-HOST,
3RD HOUR OF TODAY

CRAIG MELVIN



HOST FOR CBS SPORTS HQ,
EMMY-AWARD-WINNING SPORTSCASTER
LINDSAY CZARNIAK



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Understanding the 2026 ACS CRC Screening Guidelines





PASCALE WHITE, MD

**ASSOCIATE PROFESSOR OF MEDICINE
ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI**

**CO-FOUNDER, THE ASSOCIATION OF BLACK
GASTROENTEROLOGISTS AND HEPATOLOGISTS
ACS NCCRT STEERING COMMITTEE**

Understanding the 2026 American Cancer Society Colorectal Cancer Screening Guidelines

September 13, 2026

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Disclosures

None

Objectives

- Review colorectal cancer (CRC) data and screening modalities
 - Discuss updates to the 2026 ACS CRC screening guideline
 - Recognize strategies to increase adherence to CRC screening
-

CRC Data

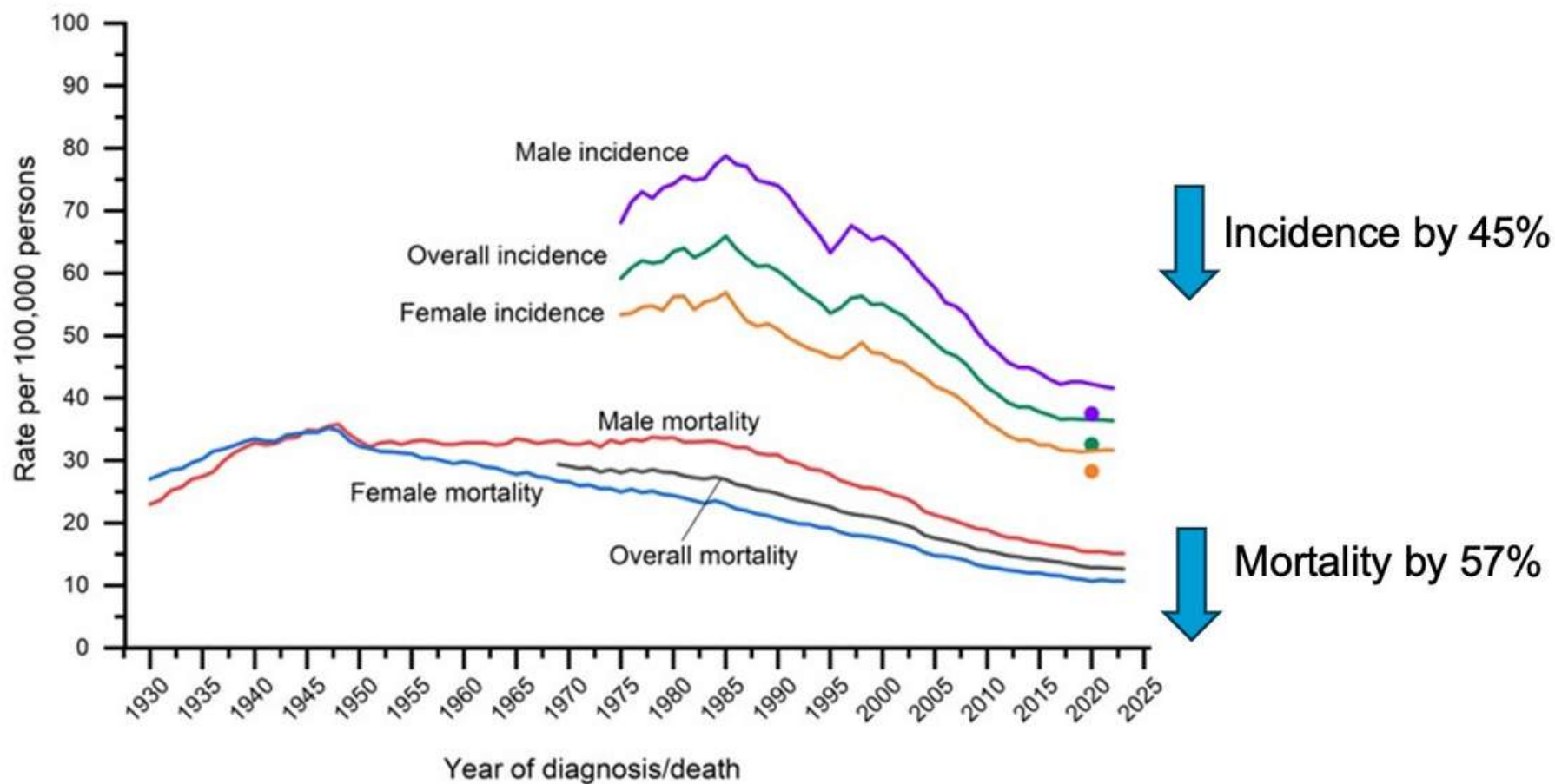
Estimated New Colorectal Cancer Cases and Deaths, 2026, US

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

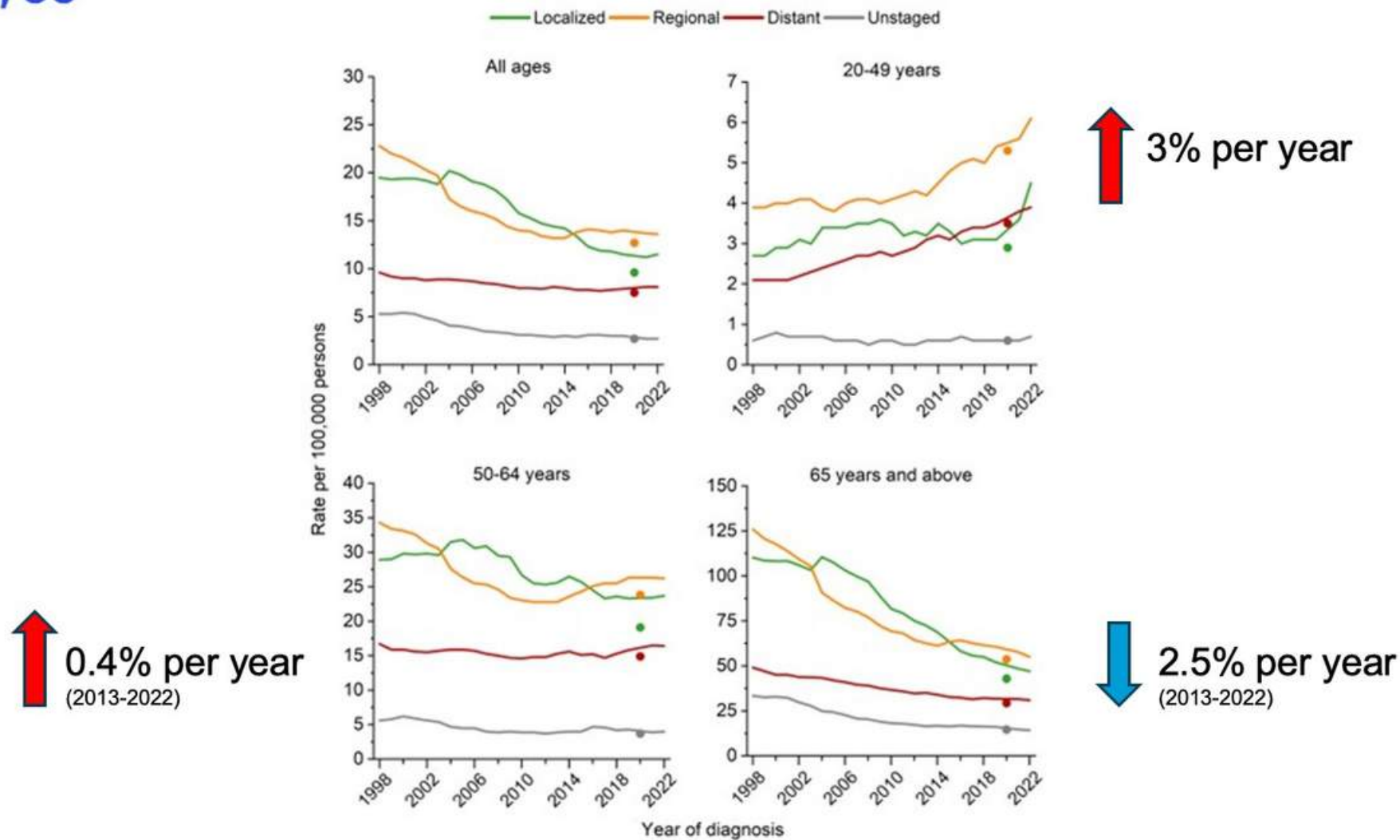
Trends in Colorectal Cancer Incidence (1975 to 2022) and Mortality (1930 to 2023) by Sex, US



Mortality includes deaths from cancer of the small intestine because of changes in the International Classification of Diseases coding over time. 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 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 Stage at Diagnosis, 1998–2022, US

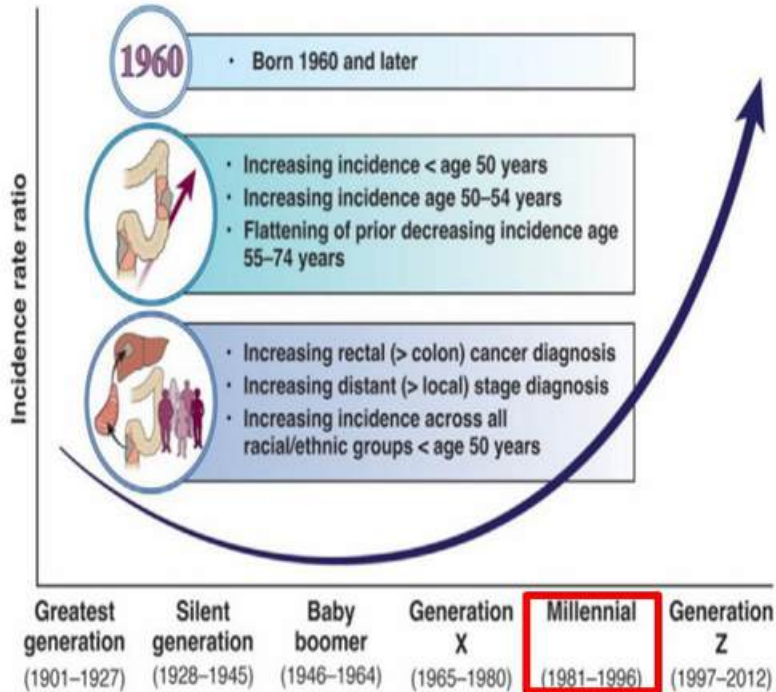


Incidence rates exclude appendiceal cancer, are age-adjusted to the 2000 US standard population and adjusted for delays in case reporting. Incidence data for 2020 are shown separate from the trend lines.

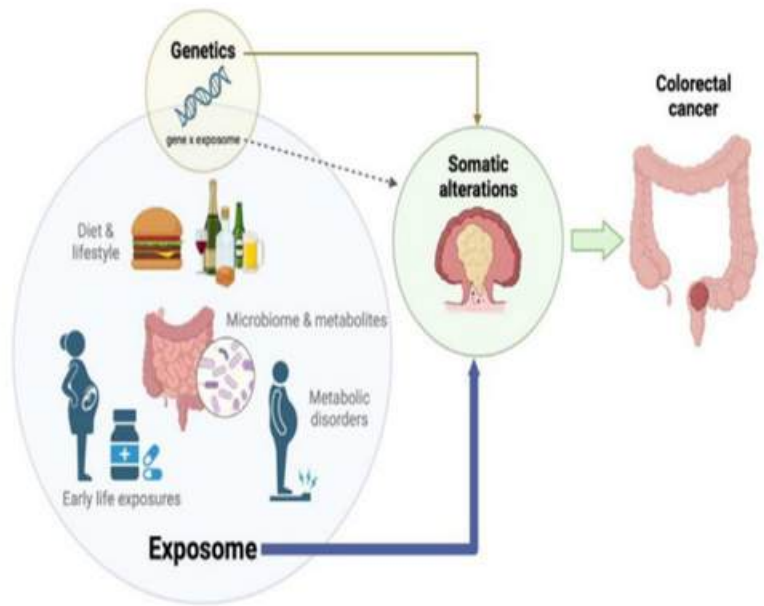
Citation: Siegel RL, Wagle NS, Star J, Kratzer TB, Smith RA, Jemal A. Colorectal cancer statistics, 2026. CA Cancer J Clin. 2026;e70067. doi:10.3322/caac.70067

Birth Cohort Colorectal Cancer

Epidemiology



Potential Causes and Mechanisms



Clinical Gastroenterology
and Hepatology

Colorectal cancer is now the #1 cause of cancer related death in people below the age of 50 in the United States

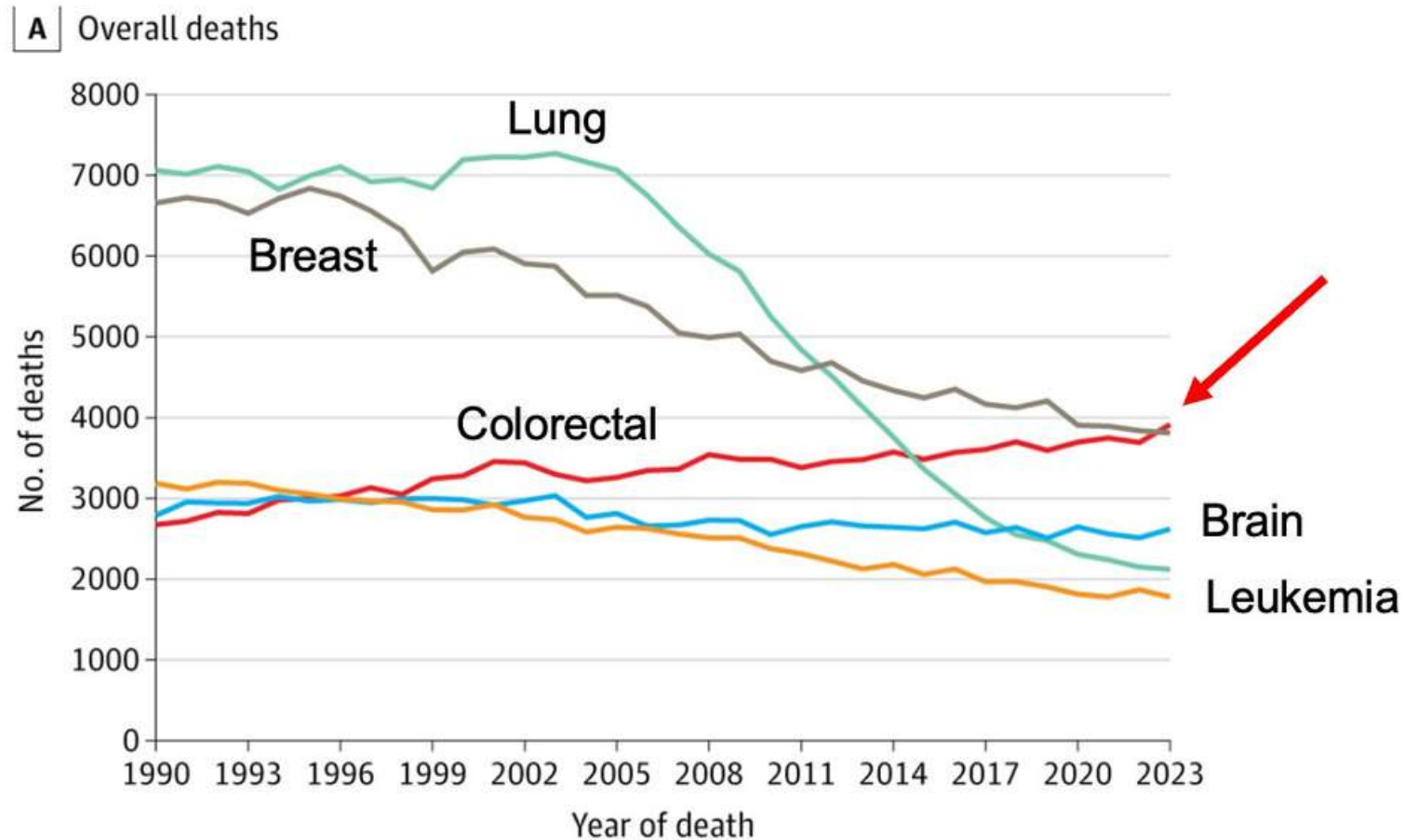


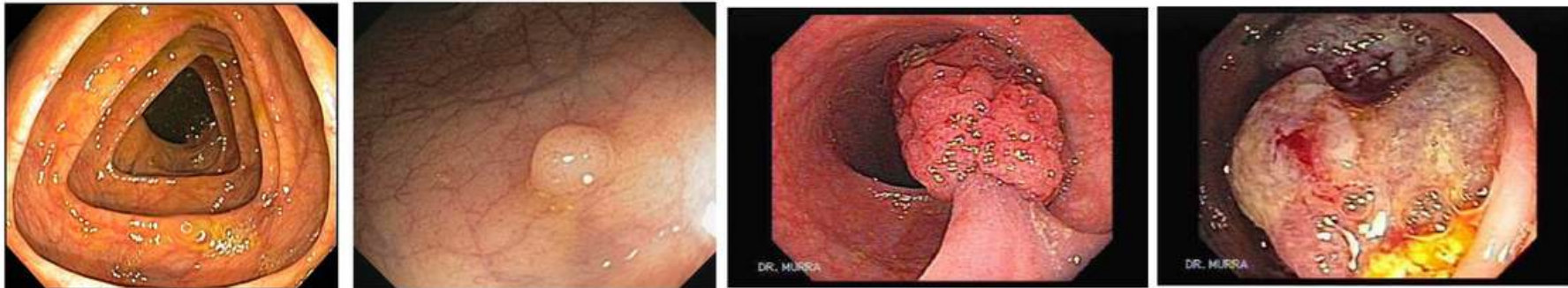
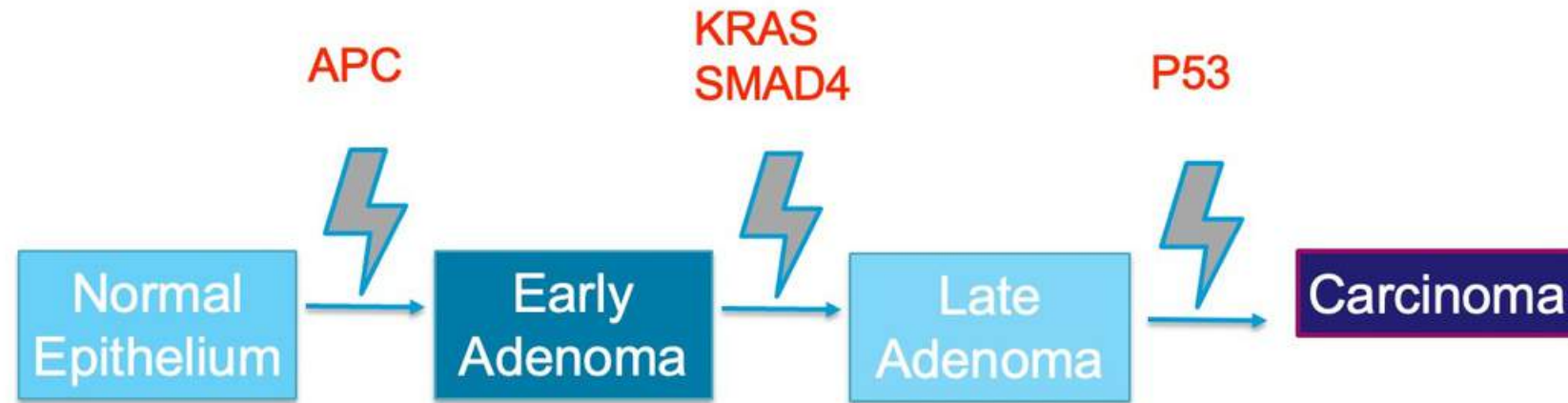
Figure. Temporal Changes in the 5 Leading Cancer-Related Deaths in People Younger Than 50 Years in the US, 1990-2023

American Cancer Society CRC Screening Guideline, 2018



CRC Screening Modalities

Adenoma to Carcinoma Pathway



Stages and 5-Year Survival Rates of CRC



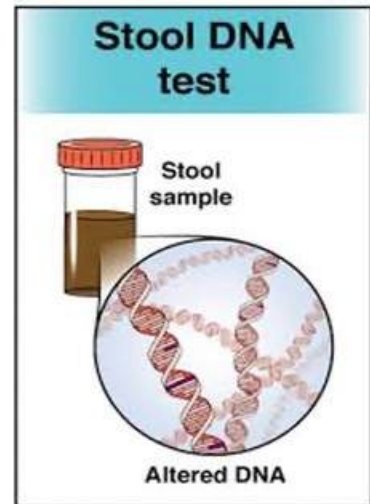
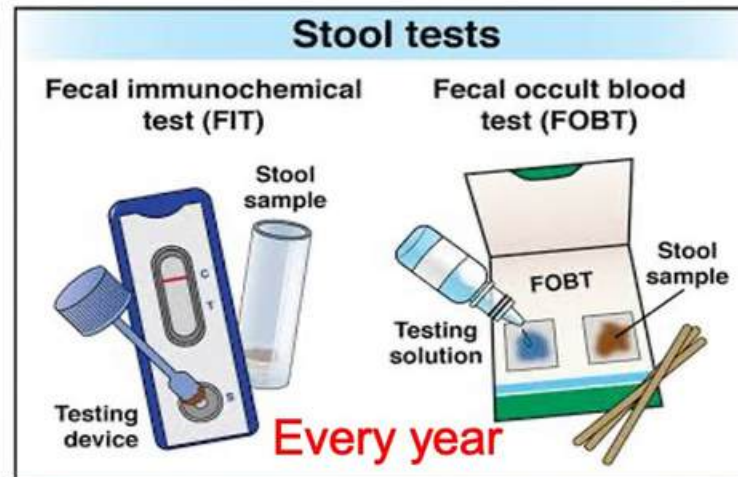
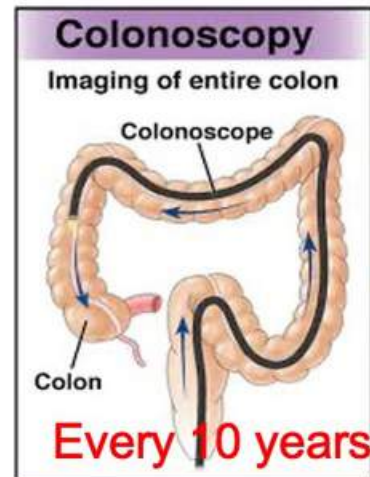
Stage I
94%

Stage II
82%

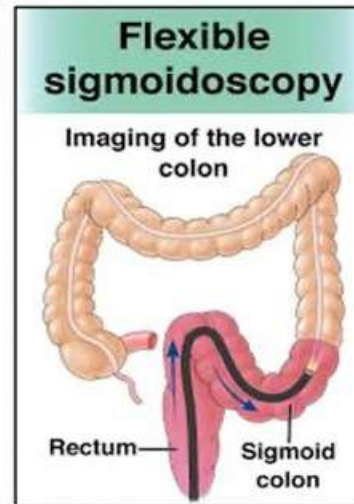
Stage III
67%

Stage IV
11%

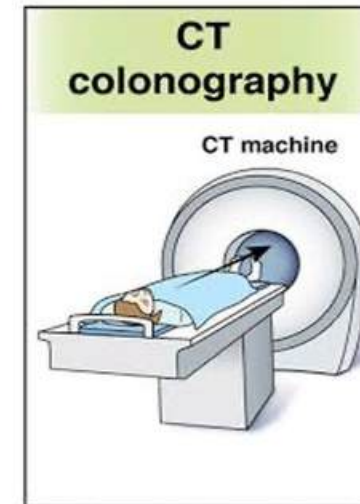
Colorectal Cancer Screening Choices



Every 3 years



Every 5 years



Every 5 years

If there is a positive stool test or findings on CT colonography, the patient must obtain a follow up colonoscopy for further evaluation, preferably within 6 months.

Stool Test Performance

	FOBT (guaiac)	FIT	mt-sDNA
Analyte	Hgb	Human Hgb	Human Hgb + DNA
At-home test	Yes	Yes	Yes
Diet/medication restriction	Yes	No	No
No. of samples	3	1	1
Detection of CRC	<50%	60-80%	80-92%
Detection of adenomas	<20%	40-60%	60-90% (size dep)
Detection of SSPs	Poor	Poor	Modest
Specificity	95-97%	94-96%	88-94%
Detection by site	Prox << Distal	Prox << Distal	Prox = Distal
Frequency	Yearly	Yearly	Every 3 years
Adherence	23-50%	40-60%	Unknown
Cost	\$20	\$75	\$600

Visual Test Performance

		Sensitivity		Specificity
		CRC	Adv. Adenoma	
Invasive Tests	Colonoscopy ¹	95%	95%	90%
	Sigmoidoscopy ¹	~50% (95% distal only)	~50% (95% distal only)	92%
	CT Colonography	96% ²	94% ³	86% ⁴

Zauber et al, AHRQ, 2009
Pickhardt et al, Radiology, 2011
Pickhardt et al, NEJM, 2003
Johnson et al, NEJM, 2008

NEW CRC Screening Modalities

Next Generation Multi-target Stool DNA (mt-sDNA) Test – Cologuard Plus

BLUE C Study

- Biomarker Panel designed to increase specificity
 - Methylated DNA markers (LASS4, LRRX4, PPP2R5C), Reference Marker (ZDHHC1), Fecal Hemoglobin

CRC

- Sensitivity: 94% (vs. 92.3% in 1st generation)
- Specificity: 91%

Advanced Precancerous Lesions

- Sensitivity: 43% (vs. 42.4% in 1st generation)
- Specificity: 90%

Table 1. Sensitivity and Specificity of the Next-Generation Multitarget Stool DNA Test and the Commercial FIT.*

Variable	Colonoscopy (N=20,176)	Next-Generation Multitarget Stool DNA Test (N=20,176)		FIT (N=20,176)	
	No. of Participants	No. of Results	Assessment (95% CI)	No. of Results	Assessment (95% CI)
			%		%
Sensitivity					
Colorectal cancer					
Any	98	92	93.9 (87.1–97.7)†	66	67.3 (57.1–76.5)
Stage I, II, or III‡	82	76	92.7 (84.8–97.3)	53	64.6 (53.3–74.9)
Advanced precancerous lesions	2,144	931	43.4 (41.3–45.6)†	500	23.3 (21.5–25.2)
High-grade dysplasia	114	85	74.6 (65.6–82.3)	54	47.4 (37.9–56.9)
Specificity					
Advanced neoplasia§	17,934	16,245	90.6 (90.1–91.0)	16,997	94.8 (94.4–95.1)¶
Nonneoplastic findings or negative colonoscopy	10,961	10,156	92.7 (92.2–93.1)	10,492	95.7 (95.3–96.1)
Negative colonoscopy**	7,510	7,012	93.4 (92.8–93.9)	7,207	96.0 (95.5–96.4)

* In evaluations of sensitivity, numbers of positive results are shown, and in evaluations of specificity, numbers of negative results are shown. Statistical analyses are presented only for comparisons of the sensitivity for colorectal cancer and advanced precancerous lesions and of the specificity for advanced neoplasia between the next-generation multitarget stool DNA test and the fecal immunochemical test (FIT). CI denotes confidence interval.

† P<0.001 for the comparison of the next-generation multitarget stool DNA test with FIT.

‡ Disease stage was defined according to the American Joint Committee on Cancer staging system.¹⁸

§ Specificity for advanced neoplasia included all participants who did not have advanced neoplasia. Absence of advanced neoplasia was defined as all nonadvanced adenomas, nonneoplastic findings, and negative colonoscopy (categories 3 through 6 in the study-specific category scheme).

¶ P<0.001 for the comparison of FIT with the next-generation multitarget stool DNA test.

|| Nonneoplastic findings or negative colonoscopy included category 6 (6.1 or 6.2).

** Negative colonoscopy was defined as no findings on colonoscopy (category 6.2).

Multi-target Stool RNA (mt-sRNA) Test – ColoSense

CRC-PREVENT Trial

- Biomarker panel measures the concentration of eight specific RNA transcripts in stool + fecal immunochemical test + participant-reported smoking history

CRC

- Sensitivity: 94%

Advanced Adenomas

- Sensitivity: 46%

***Ages 45–49:** strong performance given 100% sensitivity for CRC in this subset

Specificity: 88% (no lesions on colonoscopy)

JAMA[®]

Original Investigation

FREE

Multitarget Stool RNA Test for Colorectal Cancer Screening

Erica K. Barnell, MD, PhD^{1,2,3}; Elizabeth M. Wurtzler, PhD³; Julie La Rocca, MS³; et al

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Cell-free DNA Blood-Based Test – Shield

ECLIPSE Study

- Prospective, observational, multicenter study at 265 U.S. sites
- Coprimary outcomes were sensitivity for colorectal cancer and specificity for advanced neoplasia as compared with the colonoscopy reference standard

CRC

- Sensitivity: 83%
- Specificity: 89.6% (declines with age)

APL

- Sensitivity: 13%

Stage 1 CRC

- Sensitivity: 64.7%

Table 2. Sensitivity and Specificity of the Cell-free DNA (cfDNA) Blood-Based Test for the Most Advanced Findings on Colonoscopy.*

Variable	Most Advanced Finding on Colonoscopy	cfDNA Blood-Based Test	
		Positive Test	Sensitivity (95% CI)
	no.	no.	%
Colorectal cancer			
Any	65	54	83.1 (72.2–90.3)
Stage I, II, or III*	48	42	87.5 (75.3–94.1)
Advanced precancerous lesions†	1116	147	13.2 (11.3–15.3)
			Specificity (95% CI)
Nonadvanced adenomas, nonneoplastic findings, and negative colonoscopy	6680	698	89.6 (88.8–90.3)
Nonneoplastic findings and negative colonoscopy	4514	457	89.9 (89.0–90.7)

* Excluded were 10 stage IV and 7 pathologically confirmed, incompletely staged colorectal cancers.

† Advanced precancerous lesions include advanced adenomas and sessile serrated lesions at least 10 mm in the largest dimension.

Cell-free DNA Blood-Based Test – SimpleScreen

PREEMPT CRC Study

- Prospective, population-based, observational study across 201 centers

CRC

- Sensitivity: 79.2%
- Specificity: 91.5% (declines with age)

Advanced Adenomas

- Sensitivity: **12.5%**

Stage 1 CRC

- Sensitivity: **57.1%**

JAMA®

Original Investigation

FREE

Clinical Validation of a Circulating Tumor DNA-Based Blood Test to Screen for Colorectal Cancer

Aasma Shaukat, MD, MPH^{1,2}; Carol A. Burke, MD³; Andrew T. Chan, MD, MPH⁴; et al

» [Author Affiliations](#) | [Article Information](#)

2026 ACS CRC Screening Guidelines

ACS CRC Screening Guidelines Updated in March 2026

Unchanged

- Recommendations from 2018 ACS CRC screening guidelines

Updates

- Inclusion of the upgraded, new generation mt-sDNA test (Cologuard Plus)
 - Inclusion of mt-sRNA test (ColoSense)
 - Inclusion of blood-based DNA test (Shield)
-

ACS CRC Screening Guidelines, 2026 | Recommendations

The ACS recommends that adults aged 45 years and older with an average risk of developing CRC undergo regular screening with either a high-sensitivity stool-based test or a structural (visual) examination, depending on patient preference and test availability.

- Patients should be informed that a positive result on a non-colonoscopy screening test requires timely follow-up with a colonoscopy to complete the screening process.
- The recommendation to begin screening at age 45 years is a *qualified recommendation*.
- The recommendation for regular screening in adults aged 50 years and older is a *strong recommendation*.

ACS CRC Screening Guidelines, 2026 | Recommendations

- The ACS recommends that average-risk adults in good health with a life expectancy of greater than 10 years continue colorectal cancer screening through the age of 75 years (*qualified recommendation*).
- The ACS recommends that clinicians individualize colorectal cancer screening decisions for individuals aged 76 through 85 years, based on patient preferences, life expectancy, health status, and prior screening history (*qualified recommendation*).
- The ACS recommends that clinicians discourage individuals older than 85 years from continuing colorectal cancer screening (*qualified recommendation*).

Definition of Average-Risk Patient

People are considered to be at average risk if they **do not** have:

- A personal history of colorectal cancer or certain types of polyps (advanced precancerous lesions)
 - A family history of colorectal cancer or certain types of polyps (advanced precancerous lesions)
 - A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease)
 - A confirmed or suspected hereditary colorectal cancer syndrome, such as familial adenomatous polyposis (FAP) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC)
-

ACS CRC Screening Guidelines, 2026 | Recommendations

Preferred screening options

Stool-based tests:

- High-sensitivity fecal immunochemical test (FIT) every year
- High-sensitivity guaiac-based fecal occult blood test (gFOBT) every year
- Multitarget stool DNA test (mt-sDNA original or next-generation) every 3 years
- Multitarget stool RNA test (mt-sRNA) every 3 years

Direct visual examinations:

- Colonoscopy every 10 years
- Computed tomography colonography every 5 years
- Flexible sigmoidoscopy every 5 years

ACS CRC Screening Guidelines, 2026 | Recommendations

Recommendation for blood-based colorectal cancer screening

Blood-based screening tests are not preferred screening options at this time; they should be recommended only to individuals who decline or have not completed one of the preferred colorectal cancer screening tests.

- Blood-based tests should not be ordered without prior discussion with the patient.

ACS CRC Screening Guidelines, 2026 | Recommendations

Recommendation for blood-based colorectal cancer screening (continued)

- Patients who choose a blood-based test should be informed that:
 - Blood-based tests have **lower sensitivity** than high-sensitivity stool-based tests and direct visual examinations in detecting advanced precancerous lesions and stage I colorectal cancers, limiting their effectiveness for reducing colorectal cancer incidence and mortality relative to the preferred options
 - If their blood-based test is positive, patients will need to undergo a **follow-up colonoscopy** to complete the screening process.
 - Manufacturers have not specified a recommended testing interval; however, the Centers for Medicare and Medicaid Services specifies a **3-year interval for Medicare beneficiaries**

CRC Screening Adherence

Up-to-Date Colorectal Cancer Screening (%), 2023 NHIS

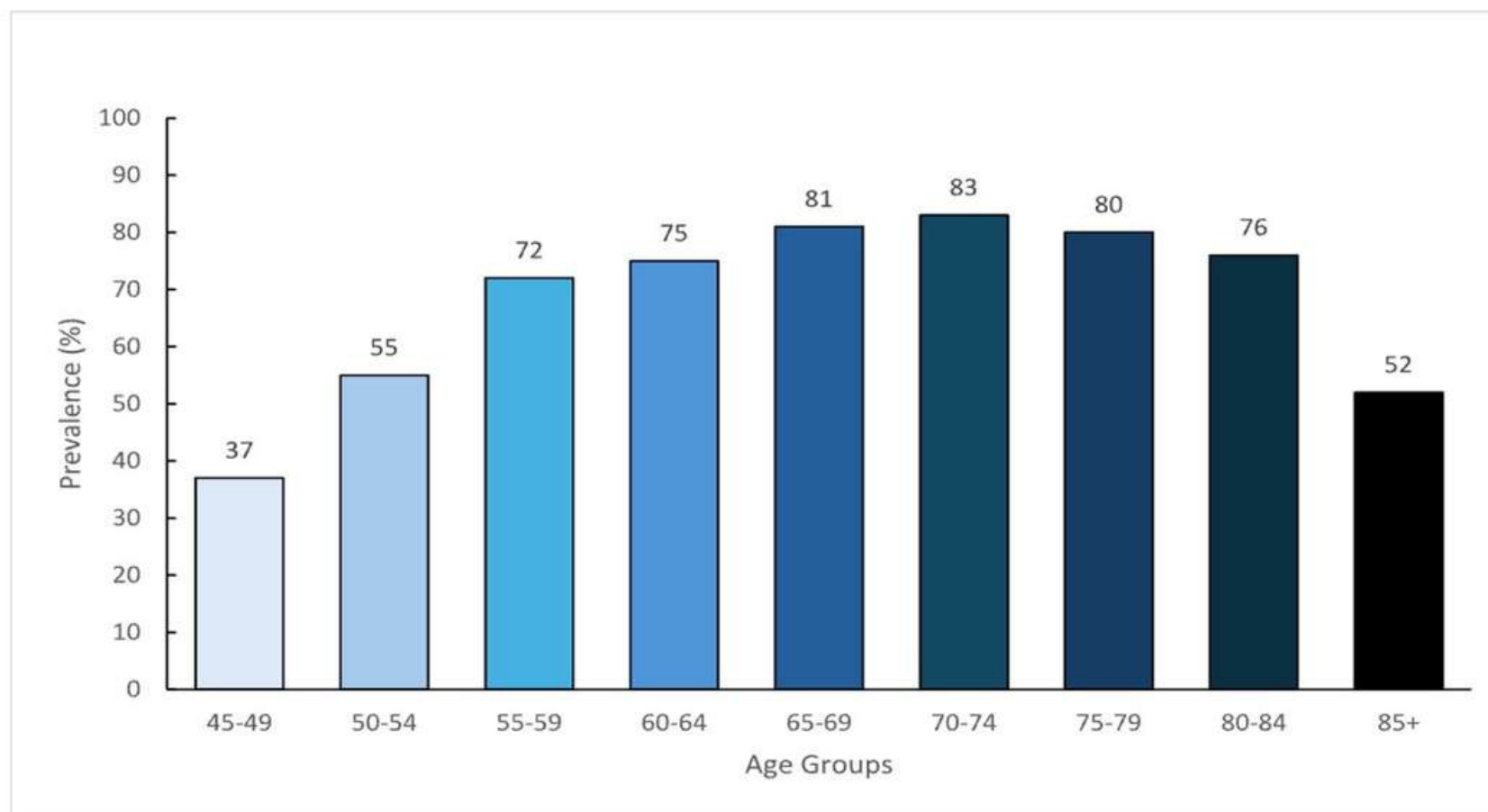
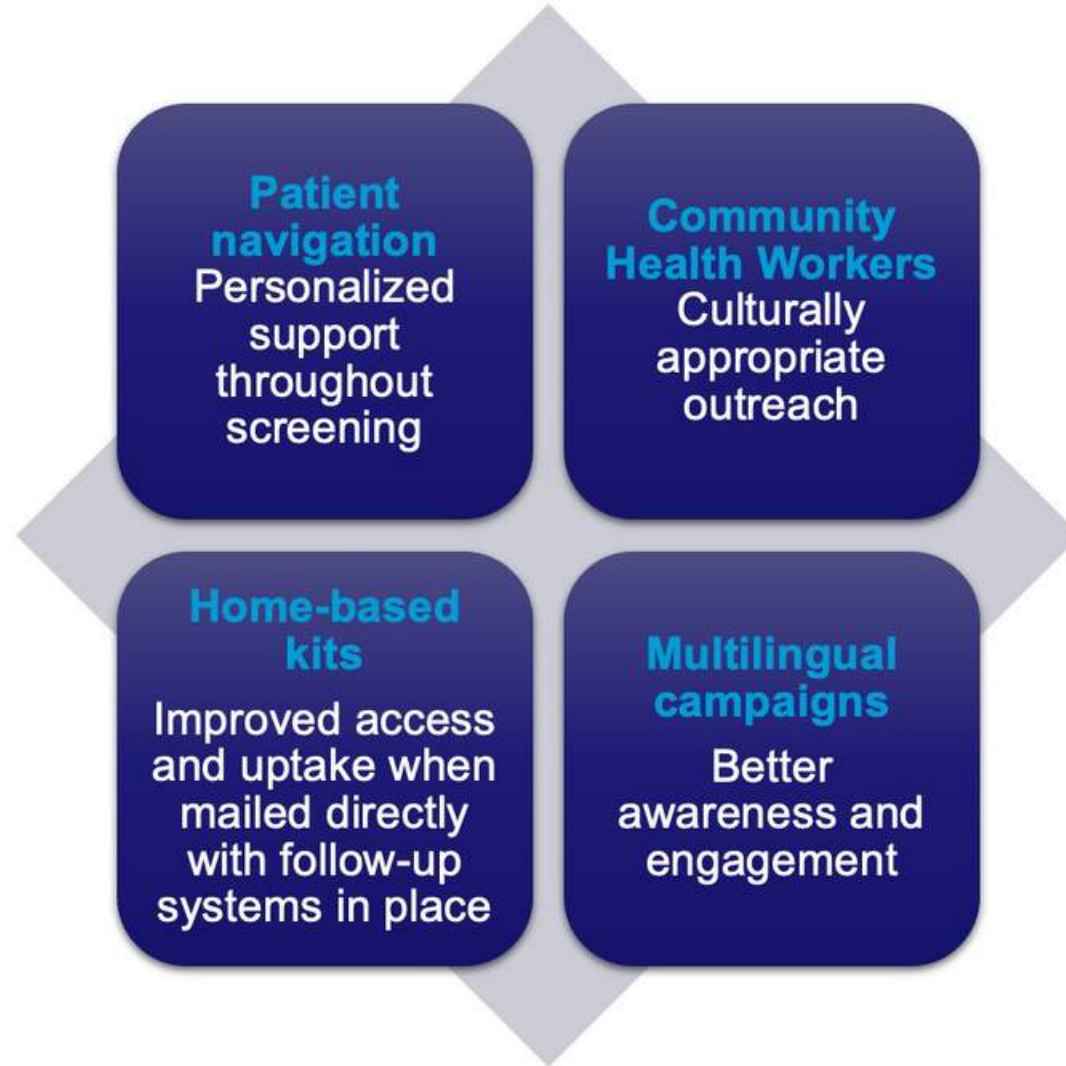
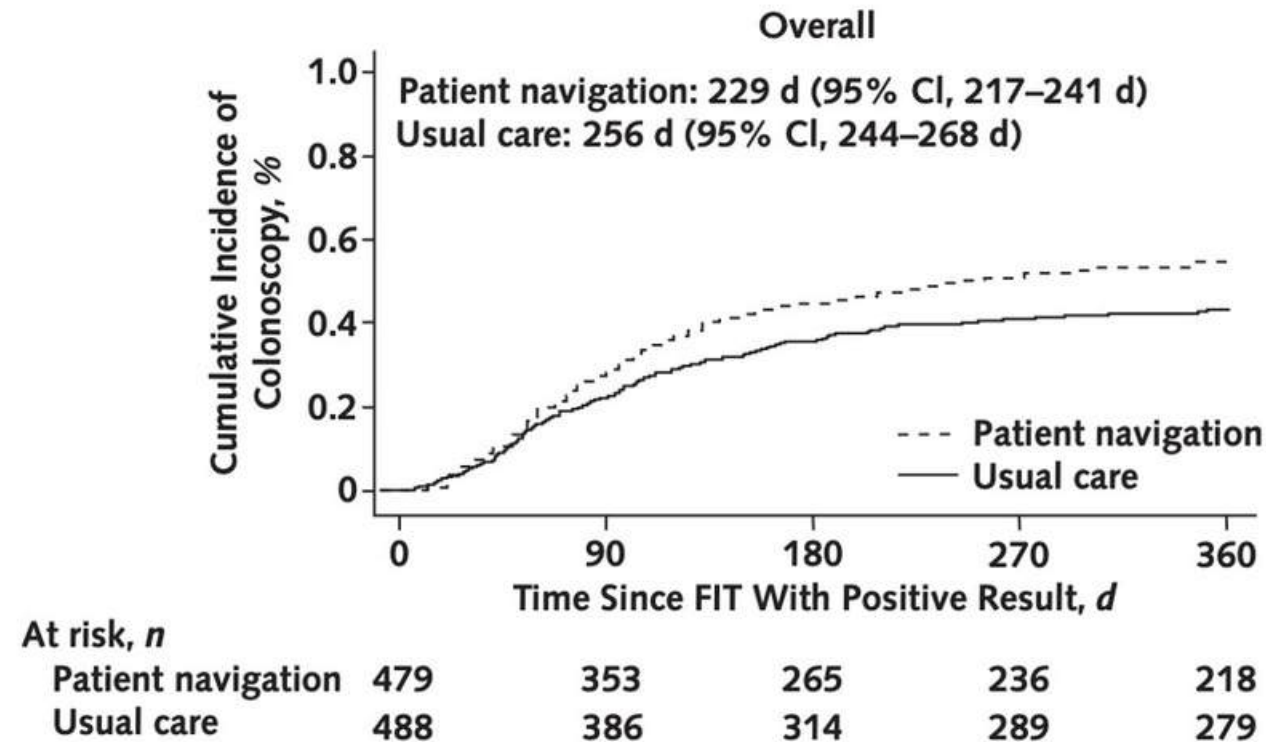


FIGURE 1 Colorectal cancer screening (%). Adults 45 years and older, by age, United States, 2023 estimates stratified by age are presented crude. Up-to-date colorectal cancer screening is defined as a fecal occult blood test/fecal immunochemical test, sigmoidoscopy, colonoscopy, computed tomography colonography, or mt-sDNA test in the past 1, 5, 10, 5, and 3 years, respectively. Source: National Health Interview Survey, 2023.

Facilitators of CRC Screening



Patient Navigation for Follow-up Colonoscopy After +FIT



Follow up colonoscopy was higher in the PN group vs Usual Care group (55% vs 42%)

Key Takeaways

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ARTICLE

Colorectal cancer screening: An update to the American Cancer Society guideline, 2026

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ABSTRACT

Colorectal cancer (CRC) is a leading cause of cancer incidence and mortality in the United States, with rates recently increasing among adults younger than 65 years. In 2018, the American Cancer Society (ACS) lowered the recommended age to initiate screening for average-risk adults to age 45 years. Since then, new molecular-based screening tests—a multitarget stool RNA test (mt-sRNA), a next-generation

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[wileyonlinelibrary.com/journal/1111-1430](https://onlinelibrary.wiley.com/journal/1111-1430) | 1 of 16



CRC is Preventable



Have Informed Discussions



Make a Choice



Get Timely Screening

Thank you!

Pascale M. White, MD, MBA, MS, FACG

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Instagram: @thestomachdocnyc



**Mount
Sinai**



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Expert Commentary



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FOUNDER, NOVA FORTIS CLINICAL RESEARCH, LLC

KEITH WINFREY, MD, MPH

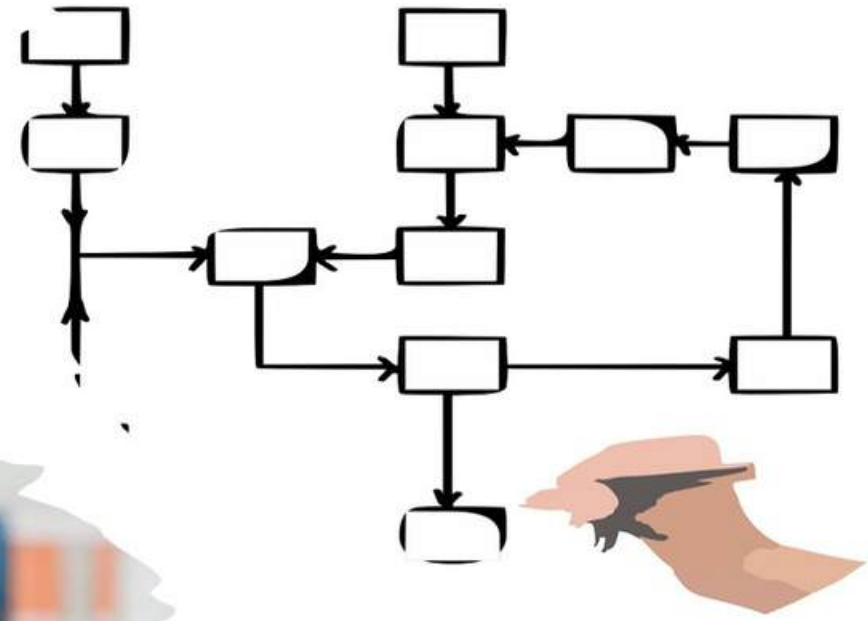
Screen Smart at Bottoms Up Invitational *Provider Perspective*

September 13, 2026



CRC Screening Success

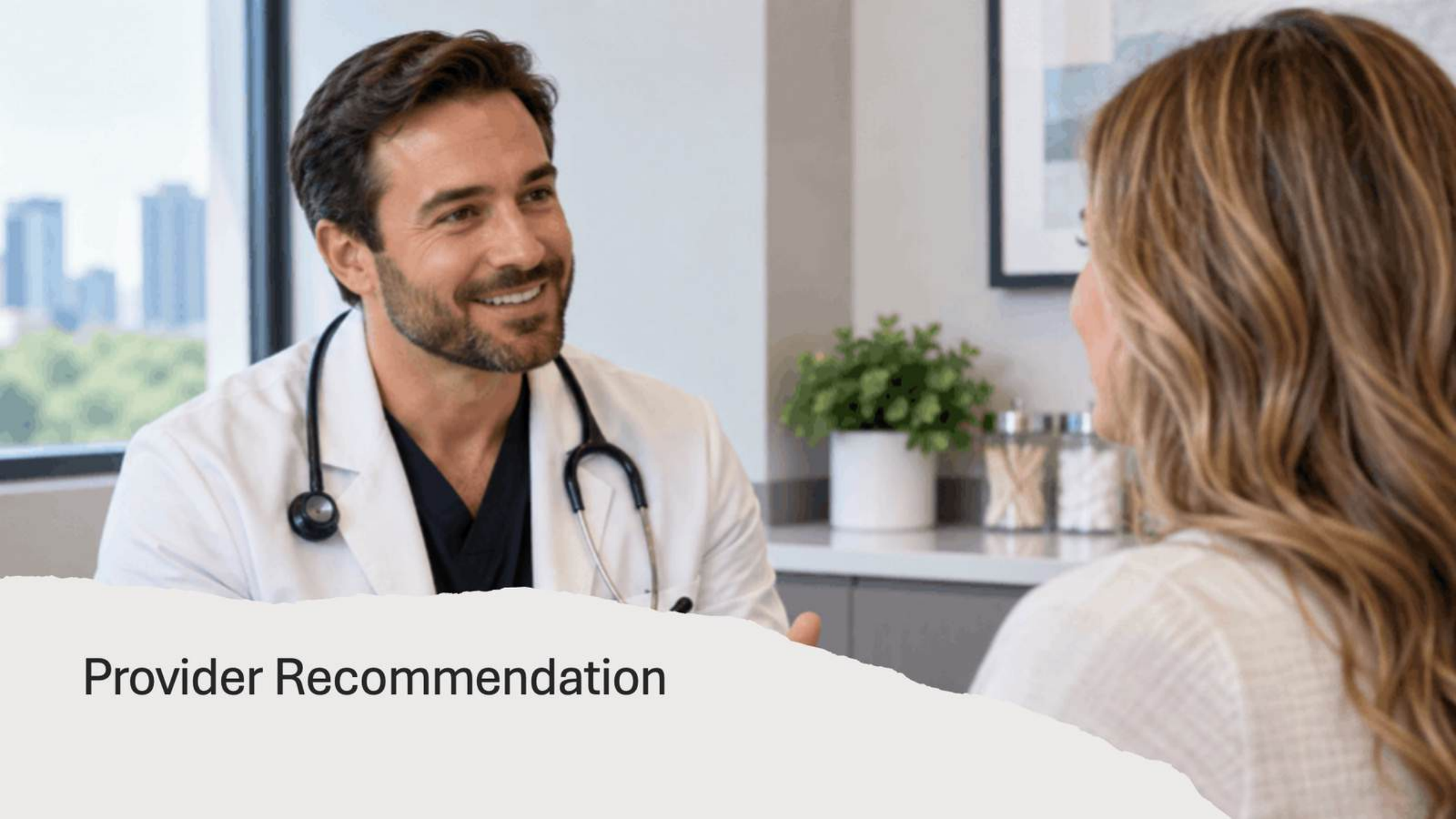
- System-Based Approach
- Patient Navigation
- Provider Recommendations



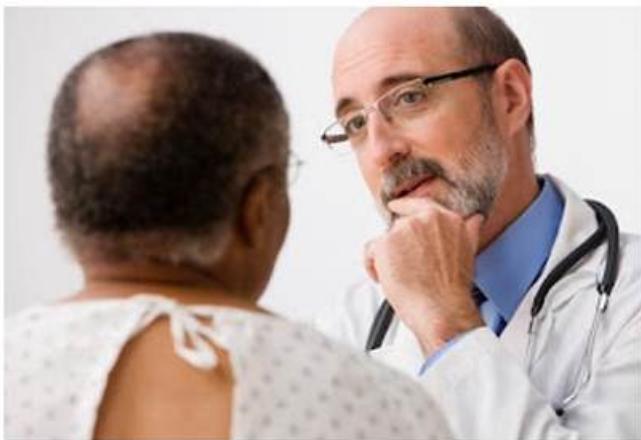
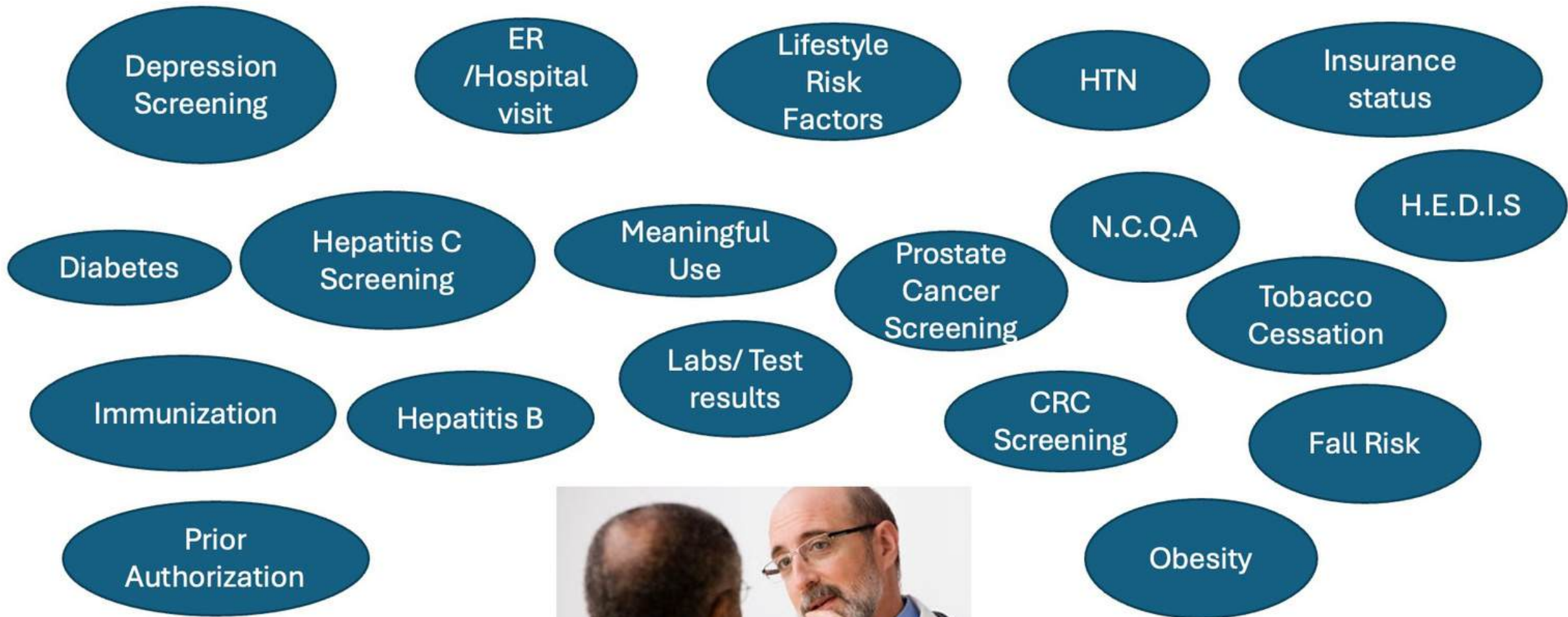
Population Health Screening

- Colonoscopy
- FIT
- Mts-DNA /ng-mts-DNA
- Mts-RNA





Provider Recommendation





2018 SURVEY OF AMERICA'S PHYSICIANS

Practice Patterns & Perspectives

An Examination of the Professional
Morale, Practice Patterns, Career
Plans, and Perspectives of Today's
Physicians, Aggregated by Age,
Gender, Primary Care/Specialists
and Practice Owners/Employees

Survey conducted on behalf of The Physicians
Foundation by Merritt Hawkins. Completed
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Revisiting the Time Needed to Provide Adult Primary Care

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BACKGROUND: Many patients do not receive guideline-recommended preventive, chronic disease, and acute care. One potential explanation is insufficient time for primary care providers (PCPs) to provide care.

OBJECTIVE: To quantify the time needed to provide 2020 preventive care, chronic disease care, and acute care for a nationally representative adult patient panel by a PCP alone, and by a PCP as part of a team-based care model.

DESIGN: Simulation study applying preventive and chronic disease care guidelines to hypothetical patient panels.

PARTICIPANTS: Hypothetical panels of 2500 patients, representative of the adult US population based on the 2017–2018 National Health and Nutrition Examination Survey.

MAIN MEASURES: The mean time required for a PCP to provide guideline-recommended preventive, chronic disease and acute care to the hypothetical patient panels. Estimates were also calculated for visit documentation time and electronic inbox management time. Times were re-estimated in the setting of team-based care.

KEY RESULTS: PCPs were estimated to require 26.7 h/day, comprising of 14.1 h/day for preventive care, 7.2 h/day for chronic disease care, 2.2 h/day for acute care, and 3.2 h/day for documentation and inbox management. With team-based care, PCPs were estimated to require 9.3 h per day (2.0 h/day for preventive care and 3.6 h/day for chronic disease care, 1.1 h/day for acute care, and 2.6 h/day for documentation and inbox management).

CONCLUSIONS: PCPs do not have enough time to provide the guideline-recommended primary care. With team-based care the time requirements would decrease by over half, but still be excessive.

KEY WORDS: Team-based care; Primary care; Preventive care; Chronic disease care; Population health.

J Gen Intern Med 38(1):147–55
DOI: 10.1007/s11368-020-03607-7

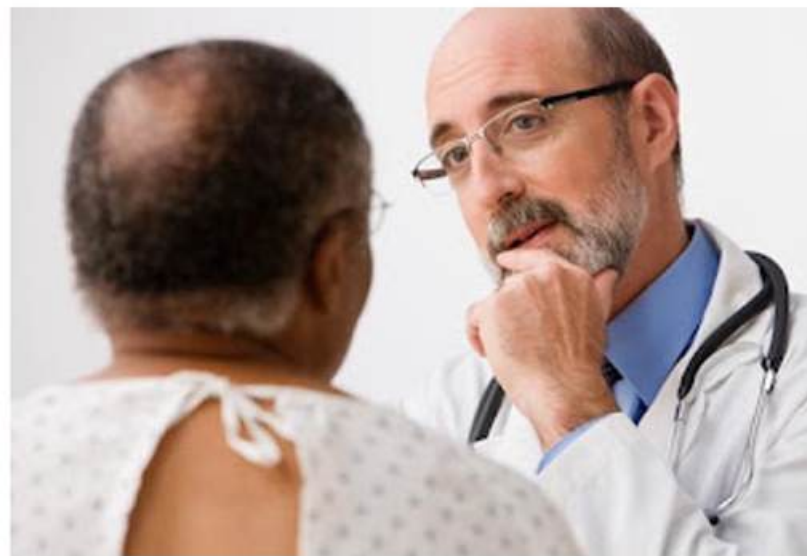
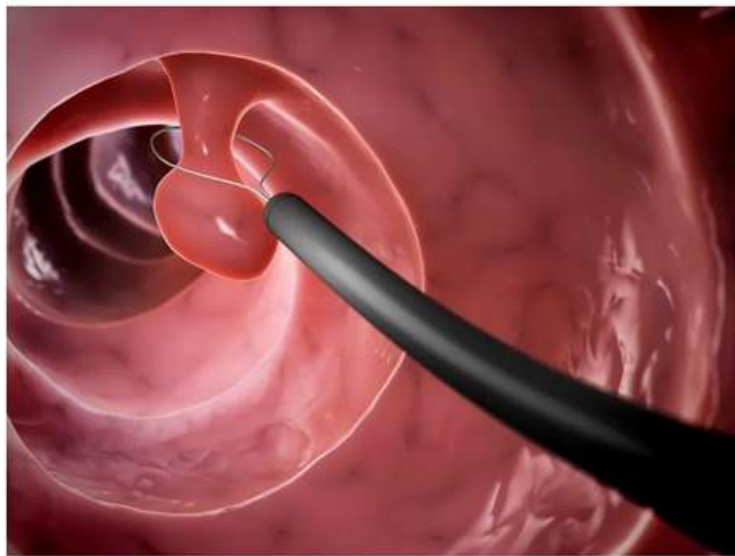
INTRODUCTION

Patients benefit from guideline-based preventive, chronic disease, and acute care,^{1, 2} but many do not receive it.³ A limitation to providing high-quality care is insufficient time.⁴ In 2003, Yarnall et al. estimated it would take 7.4 h/day for a primary care provider (PCP) to provide preventive care for a 2500 patient panel.⁶ A study by Privett et al. found it would take 8.6 h/day.⁷ A complementary study in 2005 by Østbye et al. calculated 10.6 h/day were needed for a PCP to manage the top ten chronic diseases.⁸ These studies suggested at least 18 h/per day are needed for a PCP to provide preventive and chronic care management, not accounting for other tasks.

Since 2005, there have been changes in the structure of primary care. Traditionally, PCPs cared for patients primarily by themselves. However, new team-based care models, such as the Comprehensive Primary Care Initiative Plus (CPC+), increasingly involve other care providers in providing patient care.^{9–11} Many healthcare organizations have encouraged this shift; for example, a National Academy of Medicine report urged new payment models to “pay for primary care teams to care for people, not doctors to deliver services.”¹² These models may save PCP time by shifting tasks traditionally performed by the PCP to other members of the care team. Theoretically, the time savings may allow PCPs to focus on more advanced care, see more patients, or increase the delivery of guideline-based care. Because of the potential for team-based care to change primary care practice, we re-investigated the amount of time needed to provide preventive, chronic disease, and acute care without and with team-based care.

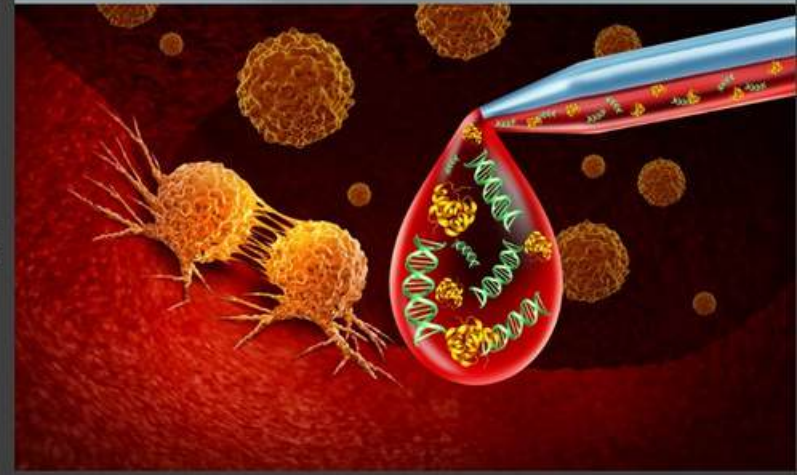
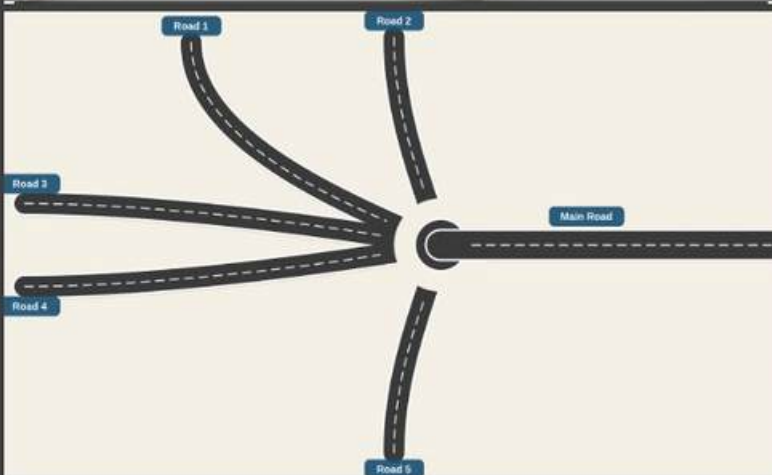
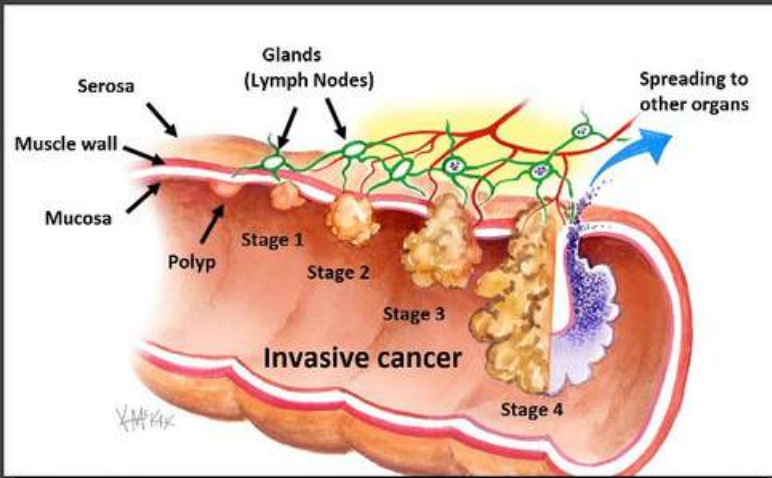
METHODS

Colonoscopy Readiness



- Have they been screened before?
- Are they willing to undergo colonoscopy screening?
- Is there a reason why they shouldn't use the system-based screening?

Provider Dilemma



Test characteristics and outcomes of CRC screening tests currently available in the U.S.2026 update

Average-risk adults; newer molecular-test estimates are from FDA/pivotal-study intended-use populations. Specificity and lesion definitions vary by study.

Test	Screening Inteval	Sensitivity for Advanced Colorectal Neoplasia	Sensitivity for CRC	Specificity	Impact on Incidence and Mortality (Compared to No Screening)
gFOBT (Hemoccult Sensa)	Annual	6 to 17%	50 to 75%	96 to 99%	RCT evidence of 20% relative incidence reduction; 18% relative mortality reduction.
FIT (OC Sensor / OC-Light)	Annual	25 to 27%	74 to 81%	95 to 96%	No RCT evidence for a specific FIT product; observational studies suggest 21% relative incidence reduction and 59% relative mortality reduction.
Next-generation mt-sDNA (Cologuard Plus)	3 years	43.3%†	95.3%†	91 to 94%†	No CRC/mortality outcomes yet from a completed screening-program RCT; pivotal study was cross-sectional.
mt-sRNA (ColoSense)	3 years	41.3%‡	92.6%‡	87.5%‡	No CRC/mortality outcomes yet from a completed screening-program RCT; pivotal study was cross-sectional.
Sigmoidoscopy	5 years	≈95%*	≈95%*	87%**	RCT evidence of 22% relative incidence reduction; 28% relative mortality reduction.
Colonoscopy	10 years	≈95%*	≈95%*	86 to 89%**	No CRC/mortality RCT versus no screening; observational studies suggest 69% relative incidence reduction and 68% relative mortality reduction.
Colon Capsule (PillCam COLON 2)	5 years	85 to 88%***	Limited data	97 to 99%	No RCT or observational outcome evidence for CRC incidence or mortality.
Blood-based cfDNA (Guardant Shield)	3 years	13% for advanced precancerous lesions§	83.1%§	89.9%§	No CRC/mortality outcome evidence yet; ECLIPSE was a prospective diagnostic-accuracy study.
Blood-based cfDNA (SimpleScreen CRC)¶	Not Established	13.7%¶	81.1%¶	90.4%¶	FDA-approved July 2026; no CRC/mortality outcome data yet. PREEMPT CRC was a prospective diagnostic-accuracy study.

† Cologuard Plus: CRC 95.3%; APL 43.3%; specificity 90.7% in the FDA pivotal study. ‡ ColoSense FDA intended-use cohort: CRC 92.6%; APL 41.3%; specificity 87.5% for no lesions on colonoscopy. § Shield ECLIPSE: CRC 83.1%; APL 13%; specificity 89.9% for negative/no-finding colonoscopy. ¶ SimpleScreen CRC: FDA-approved July 27, 2026; U.S.-Census-weighted PREEMPT CRC analysis: CRC 81.1%; APL 13.7%; specificity 90.4%. * Legacy estimates retained from the original source table. ** Specificity definitions differ by study. *** Colon-capsule estimates retained from the original source table.

Gupta S. Screening for Colorectal Cancer. Hematol Oncol Clin North Am. 2022 Jun;36(3):393-414. doi: 10.1016/j.hoc.2022.02.001. Epub 2022 Apr 30. PMID: 35501176; PMCID: PMC9167799.

Thank You!



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Panel Questions



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Panel Questions

- 1. What is your organization's approach to implementing the new ACS colorectal cancer screening guidelines?***
- 2. How are you communicating preferred versus non-preferred screening options to clinicians, payors and patients?***
- 3. What practical challenges do clinicians face when implementing the new guidelines, particularly regarding blood tests that are not widely covered by insurance? How do workflow constraints, required system changes, and patient risk stratification affect clinicians' ability to select the most appropriate tests?***
- 4. What shared messages should all stakeholders use to reduce confusion while maintaining confidence in evidence-based screening?***



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Questions & Answers



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Closing Remarks & Next Steps



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