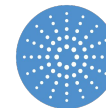


It Takes a Village: Partnering to Improve Colorectal Cancer Screenings and COL Performance

June 17, 2026



Connecting for Better Health
Advancing data sharing to improve the health of all Californians

This work is sponsored by Covered California's Population Health Investment initiative.

Welcome

While we're waiting, please: *Rename yourself*



1

Click the
Participants icon



2

Hover over your name
& click **Rename**



3

Add your name and
organization's name
**Please no acronyms*



4

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Housekeeping Reminders



Mute

We will mute lines during the presentation to prevent background noise



Questions

Submit questions using the chat feature or use the raise hand feature



Slides + Recording

Slides and recording will be shared following the meeting



Tech Issues

Private chat
Monica Dedhia for assistance

Speakers



Monica Dedhia
Senior Manager
*Population Health
Learning Center*



Andrew Maissian
Market Development
Manager
*Abbott
(formerly Exact Sciences)*



Kathryn Kane
Chief Operating
Officer
Doctors on Duty



Toria Thompson
Advisor
*Connecting for Better
Health*



Nathana Lurvey
MD FACOG
PHLC SME
*Chair of Bioethics, MLK
Jr. Hospital*



Agenda

Topic	Speaker
Introduction and Background	Monica Dedhia, Population Health Learning Center
COL Design Studio Overview and Findings	Toria Thompson, Connecting for Better Health
Outreach and Engagement	Andrew Maissian, Abbott (formerly Exact Sciences), Dr. Nathana Lurvey, MLK Jr. Hospital
Practice Participant Perspective	Kathryn Kane, Doctors on Duty
Questions and Discussion	All
Evaluation and Closing	Monica Dedhia, Population Health Learning Center



About PopHealth Learning Center

We are a team of population health experts working with 20+ health plans, 250+ providers, and purchasers to deliver:



Improved access to primary care



Streamlined processes to enhance quality and efficiency



Innovative payment models that work for practices and patients



Equity-focused tools that support care teams, patients and outcomes



Real-time data to inform decision making



Sustained population health management *at-scale*



To date, more than 2 million Californians have been served through our programs.



COL Design Studio Overview and Findings

Toria Thompson
Advisor,
Connecting for Better Health



Connecting for Better Health

Advancing data sharing to improve the health of all Californians

Connecting for Better Health




Founded in 2021, C4BH is a coalition of providers, caregivers, health plans, patient advocates, innovators, and community based organizations working to improve the state's data sharing infrastructure with a goal of transforming health and social outcomes for all Californians.

Our Vision

Every Californian and their care teams have the information and insights they need to make care seamless, high quality and affordable.



 C4BH Website



Connecting for Better Health
Advancing data sharing to improve the health of all Californians

Design Studio Summary

Problem Statement: Practices are experiencing a decline in colorectal cancer screening rates due to low patient engagement, a gap in data transfer with patients screened by other agencies, and difficulty tracking unhoused members.

Design Studio Focus: In the Colorectal Cancer Screening Design Studio, provider practices, managed care plans, and a diagnostics organization (owner of Cologuard) collaborated to identify opportunities to improve compliance, education, and data sharing.

Vision Statement: We grounded our work in the following statement:

“How might we transition from low compliance with colorectal cancer screenings to a system in which patients understand the importance and benefits of early intervention?”

Practices:



Health Plans:



Vendors:



Key Issues Identified

The Design Studio identified 3 key barriers to colorectal cancer screening and developed targeted workflows to address them:

Difficulty engaging
unhoused patients

Manual data exchange
workflows

Low patient follow
through

Design Studio Personas & Their Care Journeys



Amir Hassani

Amir is a 62-year-old Iranian male who speaks minimal English. He is currently **unhoused**, leading to difficulties with consistent communication and care. He also has an elevated A1C and is struggling to manage the condition.

Location: LA County



Ed Norris

Ed is a white, 65-year-old male. He has no health conditions and had a **colonoscopy** three years ago in San Diego but **cannot recall the details**. He is frustrated that the **FQHC does not** have his prior records.

Location: Humboldt County



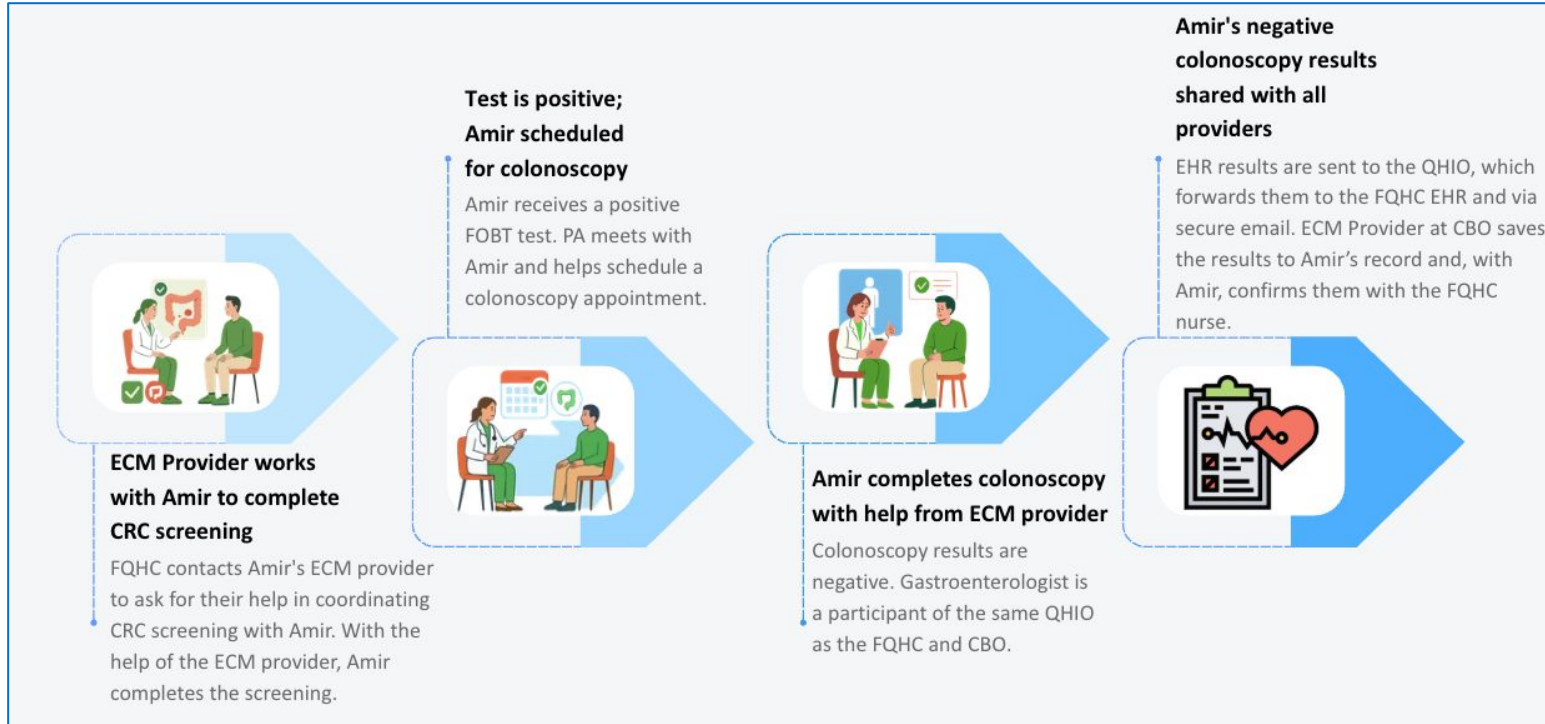
Alexa Catalan

Alexa is a 46-year-old Hispanic female. She is a single mother with two teenage children at home. She has no health conditions and is **new to COL screenings** due to the change in age requirements from **50 y/o to 45 y/o**.

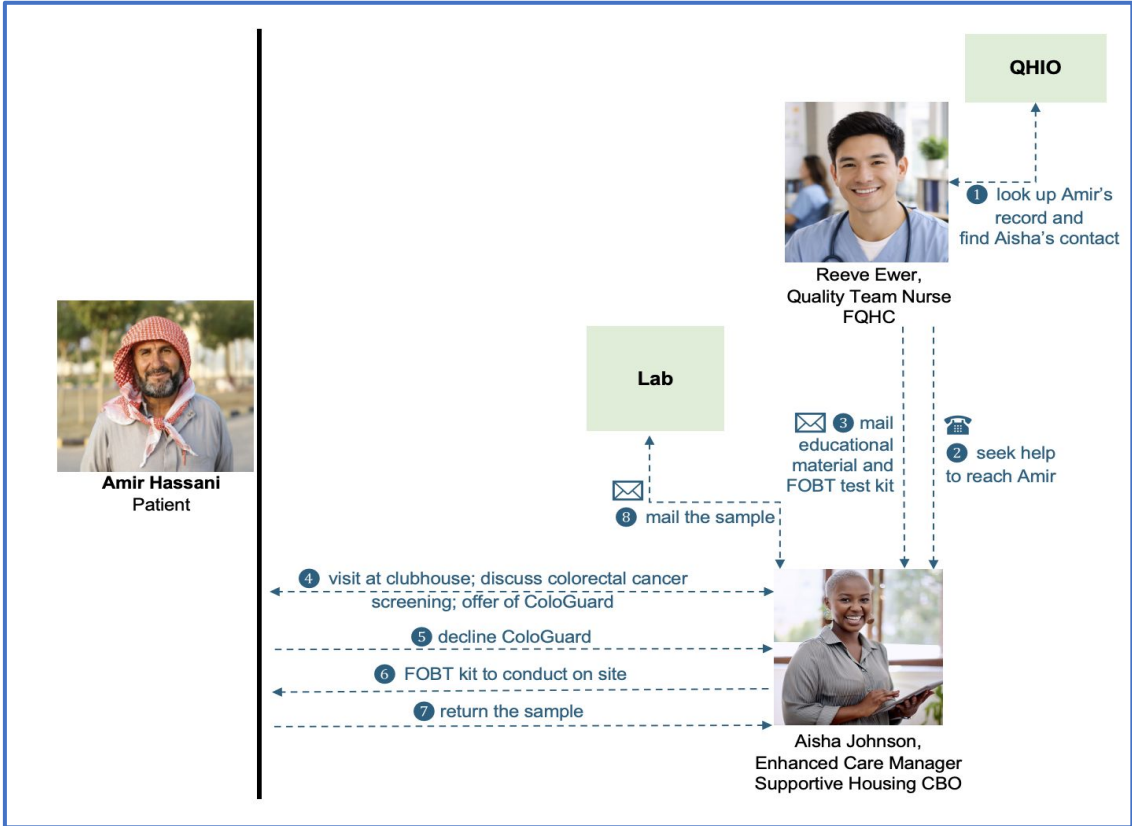
Location: Monterey County



Amir Hassani User Journey: Engaging the Unhoused



Collaborating with ECM & Other Providers for Outreach:



New Workflow:
Practices can utilize Enhanced Care Managers (ECM) who work with their high risk patients to help with outreach and engagement.

- - - - - manual interaction
————— electronic interaction

Ed Norris User Journey: Automating Data Exchange



Ed visits PCP; reports colonoscopy

After recently moving to Northern California, Ed visits his PCP for travel vaccines and reports a negative colonoscopy about three years ago in San Diego, though he does not recall the provider or exact date. The PCP documents this in the EHR.

Patient reported colonoscopy is not adequate to close COL gap

The FQHC Quality Manager uploads Ed's colonoscopy information to the MCP platform, where the MCP Quality Program Manager reviews it. Because the month and year are missing, the CRC screening gap remains open.



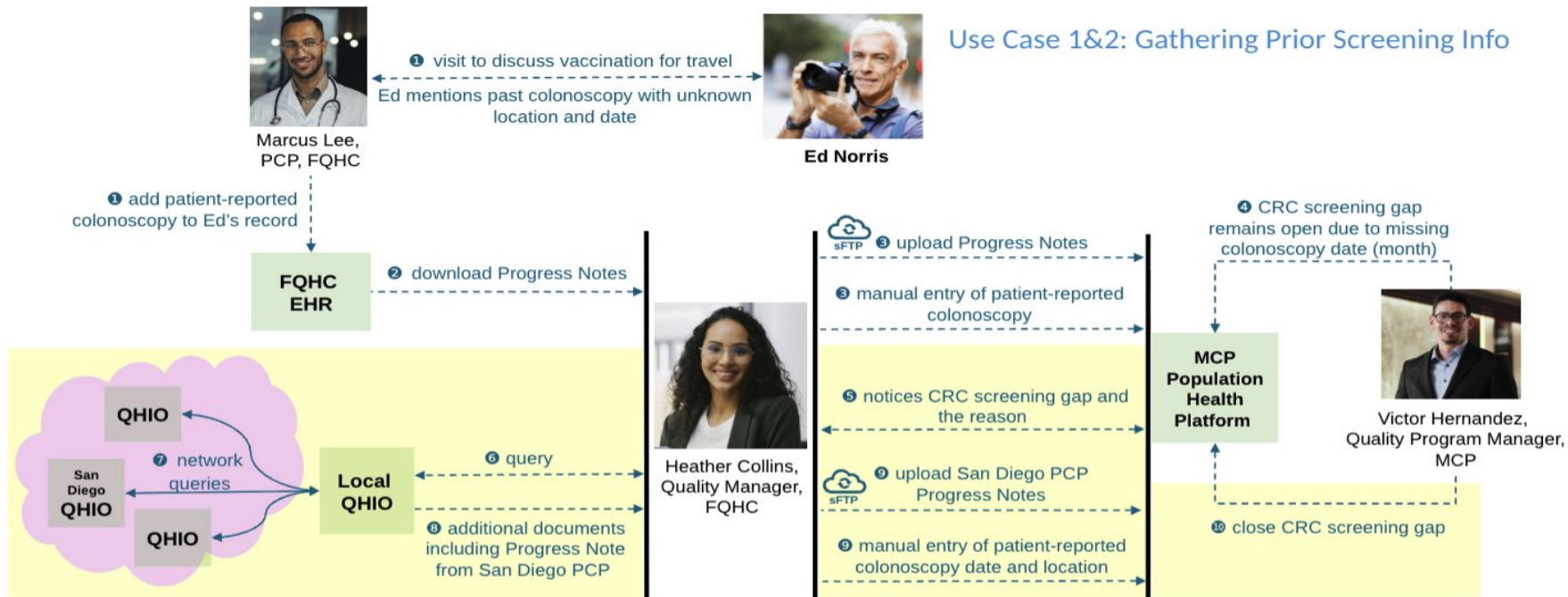
Query QHIO for colonoscopy report

The Quality Manager sees Ed's CRC screening gap is still open and uses her local QHIO to retrieve Ed's colonoscopy report from the San Diego QHIO. She then uploads the report to the MCP to close the gap in care.



Utilize QHIO* for Prior Screening Documentation

Use Case 1&2: Gathering Prior Screening Info



* A QHIO is a California regional network that enables secure health information exchange among providers, health plans, and other partners, aggregating data from multiple sources to support coordinated care.



Alexa Catalan User Journey: Improve Follow Through



Alexa tests positive for COVID; visits PCP

Alexa's PCP identifies she is overdue for a colorectal cancer screening during a visit and orders a Cologuard test kit, which is mailed directly to her home by Exact Sciences.

Despite receiving texts and emails with reminders and instructions, Alexa is still recovering and overwhelmed. She sets the kit aside, and never completes the screening.

Alexa does not complete the ColoGuard test within 60 days

While attending a school event with her son, Alexa visits a booth staffed by a Community Health Worker from her FQHC. The CHW from spots her outstanding ColoGuard order, walks her through the test instructions, and shares an incentive her MCP is offering for completing the screening. Alexa agrees to complete it that week.

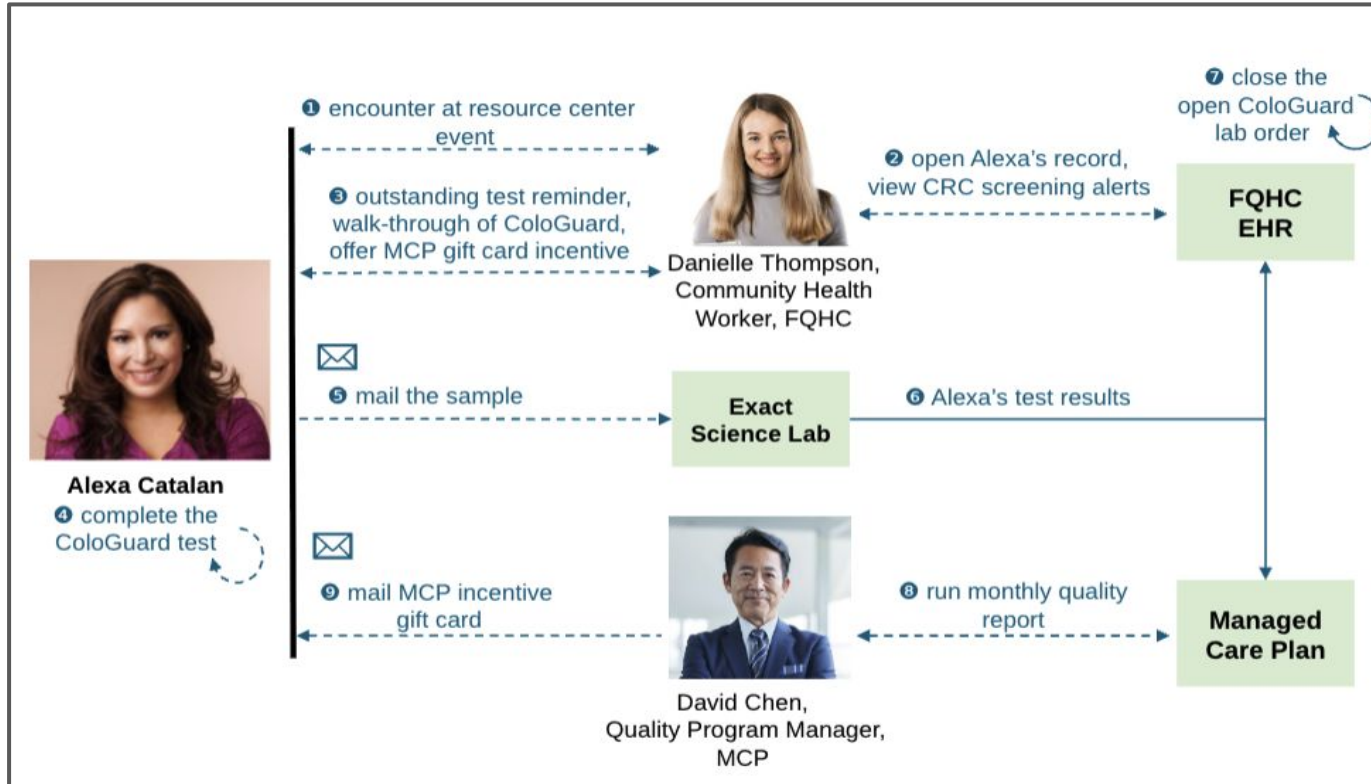


Alexa completes test and receives \$50 gift card from MCP

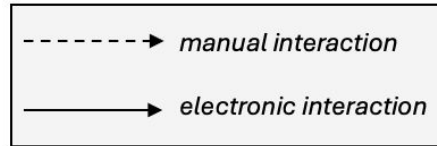
Alexa completes and mails the ColoGuard test, motivated by the gift card incentive. Exact Sciences analyzes the sample, automatically closes the order in her FQHC chart, and shares the results with her Managed Care Plan, triggering the \$50 gift card to be mailed to Alexa.



Patients Incentivized to Complete Screenings



New Workflow:
Managed Care Plan provides incentive for completion of screening.



COL Design Studio Artifacts



C4BH Sandbox: Amir Hassani Use Case

COL Playbook

Improving Colorectal Cancer Screening Rates Through Partnerships and Improved Data Exchange

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pop health LEARNING CENTER

COVERED CALIFORNIA

This work is sponsored by Covered California's Population Health Investment Initiative

June 2026

C4BH Sandbox Use Cases

- Home
- Background
- DxF Participant Directory
- Use Case Library**
- Data Explorer
- Validator Studio
- Launch Plan
- Privacy Policy
- Terms of Service
- Send Feedback
- About Connecting for Better Health
- Start Tour

← Back

Quality Measures

Colorectal Cancer Screening for an Unhoused Medi-Cal Member (COL Measure)

Amir Hassani

The Story

Amir is a 62-year-old unhoused Medi-Cal member in Los Angeles County with limited English proficiency and chronic health conditions. Due to unstable housing, language barriers, and fragmented care across multiple counties and managed care plans, he has difficulty engaging in preventive services, including colorectal cancer screening. This use case walks through how the FQHC, Enhanced Care Management (ECM) provider, laboratory, and gastroenterology practice coordinate care through QHIO-enabled data exchange to identify screening gaps, support completion of a FOBT test, schedule follow-up colonoscopy after a positive FOBT test, and ensure results are shared across providers to close the care loop.

Key Actors (8)

- Federally Qualified Health Center
- Supportive Housing CBO (ECM Provider)
- Managed Care Plan
- Gastroenterology Practice
- Laboratory
- Qualified Health Information Organization
- Case Management System
- EHR System

Journey Phases (3)

- 1 Amir receives colorectal cancer screening
- 2 After positive colorectal cancer screening, Amir is scheduled for colonoscopy
- 3 Amir completes colonoscopy and results are shared

Documents



Outreach and Engagement

Andrew Maissian,
Market Development Manager,
Abbott
(formerly Exact Sciences)

Dr. Nathana Lurvey,
MD, FACOG, Chair of Bioethics
MLK Jr. Hospital





Practice Participant Perspective

Kathryn Kane
Chief Operating Officer,
Doctors on Duty



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Current Workflow: CRC Screening

Steps

1. Patient identified as due for CRC through EPIC care gap tools
2. Care gap is visible to Providers, Medical Assistants, Population Health staff
3. Screening discussed during:
 - Annual wellness visits
 - Follow-up appointments, urgent care visits
 - Telemedicine outreach
4. Orders placed for:
 - Colonoscopy referral
 - FIT kit
 - Cologuard
5. Results indexed into EPIC
6. Care gap closes when valid screening documentation is received



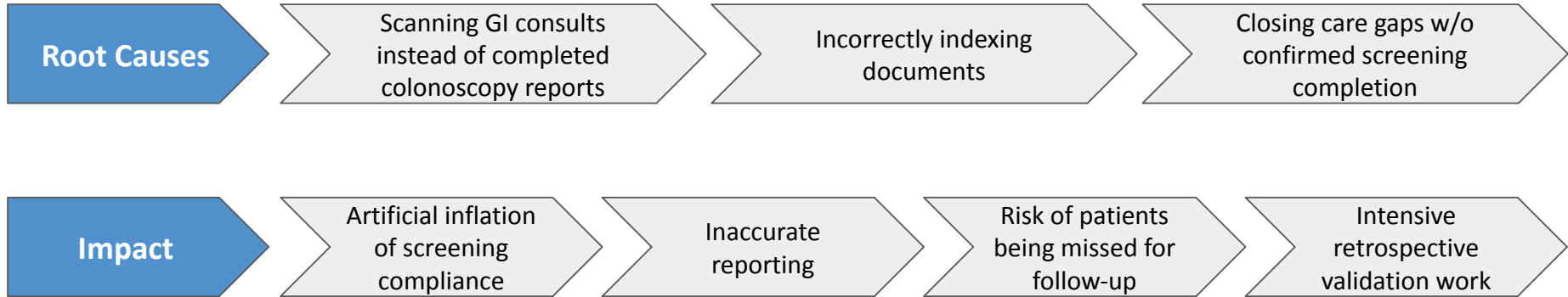
Existing Population Health Support



- Outreach calls to overdue patients
- Preventative care reminders
- Pre-visit planning reviews
- Care gap closes when valid screening documentation is received

Workflow Issue Identified

While reviewing performance data and conducting chart audits, we identified a **significant workflow issue** impacting our CRC screening metrics.



Corrective Action Taken

Data Validation and Chart Audit Process

Ensuring accurate reporting

Conducted extensive chart audits and data validation reviews

Reviewed more than 1,000 patient records

Validated whether:
Screening was truly completed, Correct documentation existed, Care gaps were appropriately closed

If records were incomplete/scanned incorrectly:

Staff manually requested colonoscopy reports from specialists/facilities

Records had to be re-indexed appropriately

Care gaps were reopened when necessary

Interoperability Challenges

Current Limitations

- We were not yet interfaced with a QHIO
- Outside procedure records were difficult to retrieve efficiently
- Manual record requests created delays and staff burden

Future State Improvement

We are now in the final stages of implementing an interface with **Manifest MedEx**

Expected Benefits

- Improved access to outside colonoscopy reports
- Faster record reconciliation
- Reduced manual chart abstraction
- More accurate and timely care gap closure
- Enhanced population health reporting capabilities

Future Population Health Strategies

Partnership with Abbott/ Exact Sciences

Bulk Outreach Strategy

Identify all eligible patients due for colon cancer screening

Utilize bulk ordering for ColoGuard

Abbott to send co-branded patient outreach letters

Enhancing Patient Engagement

Exploring Use of Community Health Workers (CHWs)

Provide patient education on: benefits of early detection, screening options, at-home testing convenience

Address barriers and misconceptions

Improve screening follow-through

Why This Matters

Providers Are Often Time Constrained During Appointments

Community Health Workers can provide:

- Dedicated education time
- Motivational support
- Culturally responsive outreach
- Barrier identification and resource connection

Questions and Discussions



Let Us Know How We Did!



Appendix



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Key Learnings: Low Patient Engagement

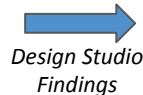


Issue

- Providers struggle to integrate preventative care conversations during acute care visits.

Impact

- Lack of COL compliance
- Delayed/missed detection of colorectal cancer



Learnings and Recommendations

Learnings

- Providing Cologuard kits on-site improves screening completion rates and enhances patient engagement.

Recommendations

- Scheduling follow-up appointments
- Have test kits on-site (particularly for unhoused)
- Provider education on current best practices
- Offer incentives for patients to complete colorectal screenings and see a specialist if results are positive



Key Learnings: Unhoused Population

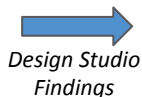


Issue

- Challenges outreaching to individuals experiencing homelessness and ensuring continuity of care.

Impact

- Negative health outcomes, lack of traceability.



Learnings and Recommendations

Learnings

- External community partners are essential for identifying individuals experiencing homelessness, improving care coordination, and ensuring continuity of care.

Recommendations

- Engage other care team members such as ECM, Home Health, SNF/Assisted Living providers
- Use outreach tools such as text messaging and other automated notifications
- Offer Cologuard kits in clinic



Key Learnings: Data Transfer



Issue

- Challenges outreaching to individuals experiencing homelessness and ensuring continuity of care.

Impact

- Delayed screening and service delivery, decrease in patient satisfaction



Design Studio Findings

Learnings and Recommendations

Learnings

- Providers can use data exchange tools that aggregate data from multiple sources to have more accurate and up to date patient information.

Recommendations

- Utilize Cozeva and QHIOs to reconcile data
- Collaborate with Cologuard to access a large database for reconciliation

