

# Improving access to cancer screening through national telehealth-based lung and colorectal cancer screening programs



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## Background

Routine cancer screening remains inaccessible for many individuals, particularly those in historically underserved and rural communities who face financial, geographic, or logistical barriers to care. Virtual care models may help reduce these barriers, but their impact on cancer screening uptake is not well understood. In collaboration with the American Cancer Society (ACS), Color launched two national telehealth-based programs aimed at expanding access to colorectal and lung cancer screening. This evaluation examines the reach and implementation of these programs in diverse community settings.

## Program overview

The Colorectal Cancer Screening Program, launched in June 2024, provides at-home fecal immunochemical tests (FIT) to individuals based on ACS guidelines. Kits are distributed through Federally Qualified Health Centers (FQHCs) and community-based outreach, including rural libraries and community centers.

The Lung Cancer Screening Program, launched in November 2023, offers free low-dose CT scans to eligible individuals nationwide, based on ACS guidelines. Color supports the full screening process, including risk assessment, physician orders, appointment scheduling, and follow-up coordination.

Both programs use a virtual-first model that enables participants to complete a self-reported health history, access educational resources, and receive personalized support from care advocates who guide them through test navigation, results delivery, and linkage to follow-up care (**Figure 1**).

Figure 1. Program Overview



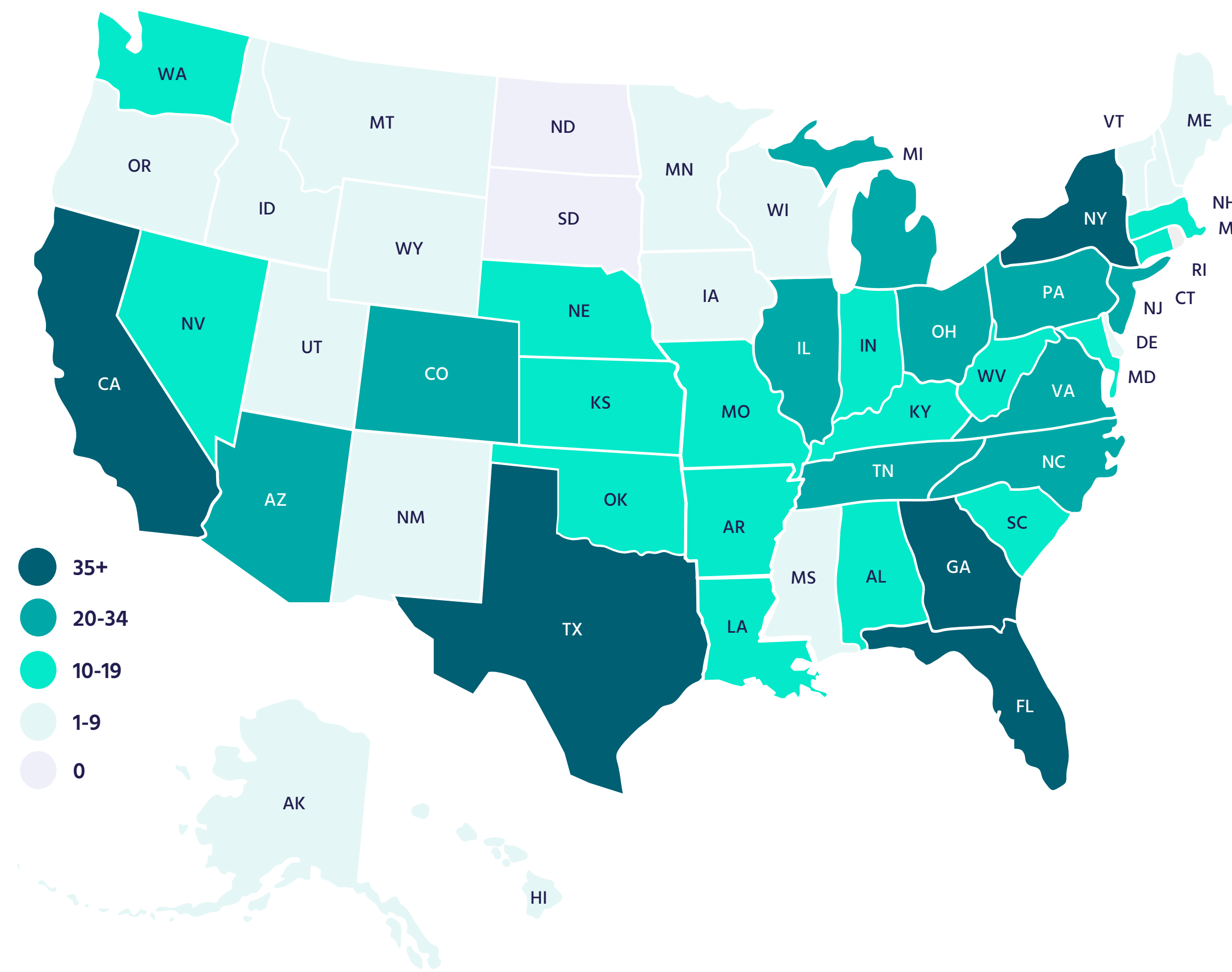
## Program eligibility

Eligibility for both programs is determined through a brief online risk assessment. For colorectal cancer screening, individuals must be 45–75 years of age and at average risk for colorectal cancer. For lung cancer screening, individuals 50–80 years of age with a ≥20 pack-year smoking history, may be eligible for a low-dose CT scan in accordance with ACS guidelines (**Table 1**). Both programs are available regardless of insurance status. Color care advocates assist with identifying low- or no-cost in-person care and provide support in multiple languages.

Table 1. Program Screening Guidelines

	ACS Lung Cancer Screening Guideline <i>Last updated: November 2023</i>	ACS Colorectal Cancer Screening Guidelines <i>Last updated: March 2021</i>
Age to start	50 years	45 years
Age to stop	80 years	75 years
Other eligibility requirements	20 smoking pack years	Average risk for colorectal cancer
Exclusion criteria	<ul style="list-style-type: none"><li>Active lung symptoms</li></ul>	<ul style="list-style-type: none"><li>Personal history of colorectal cancer or polyps</li><li>Diagnosed inflammatory bowel disease (e.g., Crohn's, ulcerative colitis)</li><li>High-risk hereditary syndromes (e.g., Lynch syndrome, FAP)</li><li>Active gastrointestinal symptoms (e.g., rectal bleeding)</li></ul>

Figure 2. Nationwide reach and interest



## Results: Enrollment

As of May 2025, a total of 886 individuals expressed interest in participating in the colorectal or lung cancer screening programs. Participants were predominantly female, with 60.8% (n=426) identifying as female in the colorectal cancer program and 60.5% (n = 112) in the lung cancer program (**Table 2**). The average age of participants was similar across programs: 50.4 years (range: 18–90) in the colorectal program and 53.3 years (range: 18–81) in the lung program. Race/ethnicity was not collected for the colorectal program; the majority of individuals who expressed interest in the lung program were White (72.4%).

In the lung cancer screening program, 185 individuals completed the online health risk assessment. A substantial portion had a smoking history, with 33.0% (n=61) reporting current smoking and 54.6% (n=101) reporting former smoking. Of those who reported smoking, the average reported smoking history was 24.7 pack-years, with a range from 0.05 to 110 pack-years. Interested participants resided across 36 states, with the highest representation from Florida and Texas (**Figure 2**). In the colorectal cancer screening program, 701 individuals picked up or requested FIT kits through community-based outreach and distribution via federally qualified health centers (FQHCs). Interested participants resided across 49 states, with the largest proportions coming from Texas (10.3%), California (7.8%) and Florida (7.1%). Participant demographics were generally reflective of the targeted rural and underserved populations, though detailed race and ethnicity data were not collected for this program at the time of reporting.

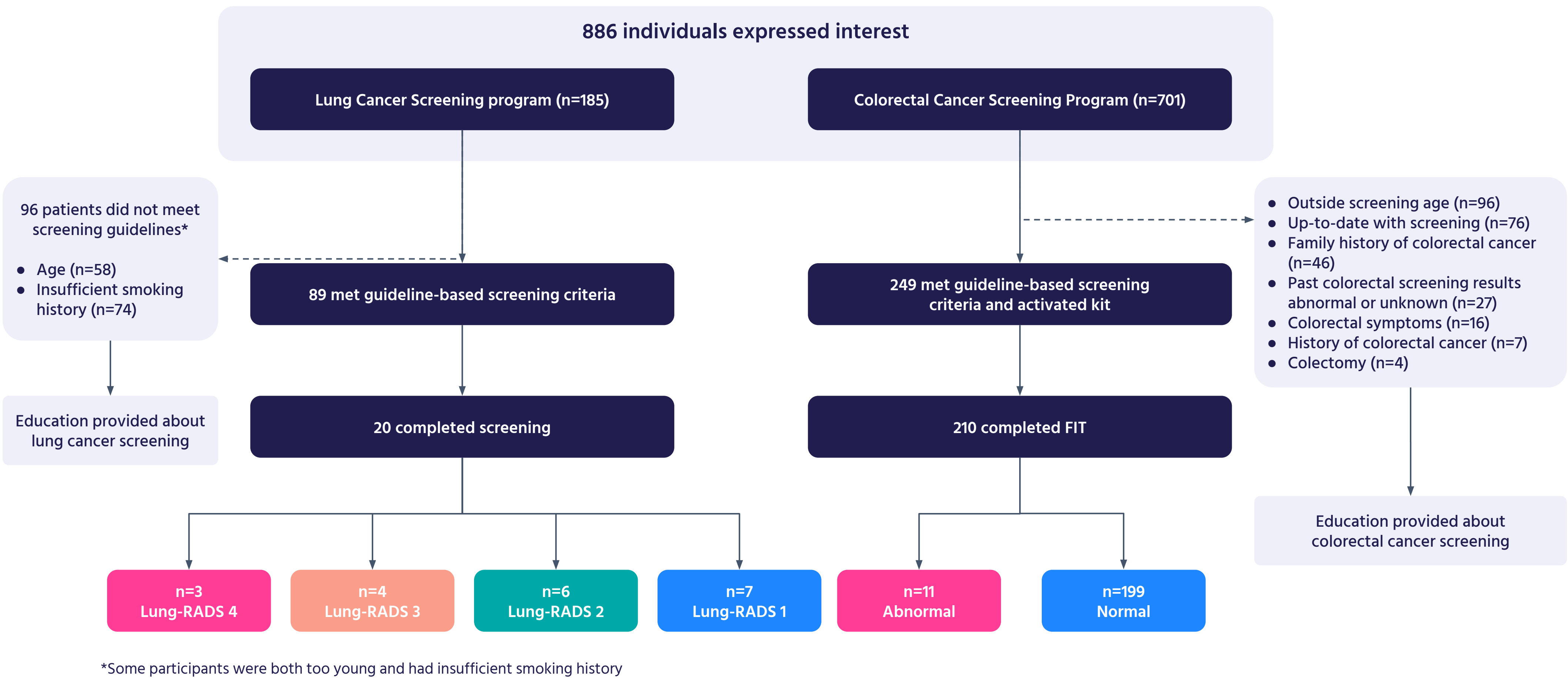
Table 2. Participant demographics

		Completed risk assessment (N=185, 100%)	Eligible for screening (N=89)
Age at enrollment	Average	53.3 years	61.1 years
	Range	18 - 81 years	50 - 78 years
	Female	112 (60.5%)	57 (64.0%)
Sex assigned at birth	Male	73 (39.5%)	32 (36.0%)
	Female	73 (39.5%)	32 (36.0%)
Race/Ethnicity (self-reported)	Asian/Pacific Islander	8 (4.3%)	2 (2.2%)
	Black or African American	10 (5.4%)	2 (2.2%)
	Hispanic or Latino of any race	14 (7.6%)	3 (3.4%)
	Multiethnic	9 (4.9%)	3 (3.4%)
	Native American or Alaskan	4 (2.2%)	1 (1.1%)
	White	134 (72.4%)	77 (86.5%)
	No response	6 (3.2%)	1 (1.1%)
Smoking history	Currently smoke	61 (33.0%)	28 (31.5%)
	Previously smoked	101 (54.6%)	61 (68.5%)
	No smoking history	18 (9.7%)	N/A
	No response	5 (2.7%)	N/A
Smoking pack years	Average	21.4 PYs	34.4 PYs
	Range	0.05 - 110 PYs	20 - 110 PYs

## Colorectal Screening Program

		Completed risk assessment (N=701, 100%)	Eligible by ACS, completed kit (N=210)
Age at enrollment	Average	50.4 years	54.0 years
	Range	18 - 90 years	45 - 75 years
Sex assigned at birth	Female	426 (60.5%)	130 (61.9%)
	Male	275 (39.2%)	30 (38.1%)

Figure 3. Flow diagram of program participation



## Results: Colorectal screening results

In the colorectal cancer screening program, 249 individuals who received a FIT kit met eligibility criteria and activated their kits. The most common reasons for ineligibility included being up-to-date with colorectal cancer screening (24.6%, n=76) and being outside of the eligible age range (31.1%, n=96) (**Figure 3**). As of May 2025, 84.3% (n=210) of eligible participants with an activated kit completed and returned the FIT test – an additional 12 eligible patients received their kit within the past two months and may still return their kit. Of those who returned their kit, 11 participants (5.2%) received an abnormal result and were referred for diagnostic colonoscopy. All participants in both programs received ongoing support from care advocates, including guidance on test completion, eligibility navigation, and coordination of follow-up care when needed.

## Results: Lung screening results

A total of 20 eligible participants (22.5%) proceeded to complete a lung CT scan; an additional three patients signed up for the program within the last 2 months and are in the scheduling process (**Figure 3**). The average time from risk assessment to scheduled appointment was 29 days (range: 9–93) and the average distance between a participant’s preferred location and imaging center appointment was 10.0 miles. Clinically significant findings (Lung-RADS 3 or 4 nodules) were observed in 35.0% of those scanned (n=7); additional incidental findings were identified, requiring clinical follow-up (**Table 3**).

Table 3. LDCT results

		Result - Lung	Result - Incidental	Recommendation for lung results
1	Lung-RADS 4	Patchy bilateral areas of peribronchovascular reticulonodular and ground-glass opacities as well as focal areas of pure ground-glass opacity in both lungs. Multiple small lung nodules, measuring up to 9 mm in size.	Mild coronary artery calcification and aortic atherosclerosis.  3.7 cm liver cyst.  9 mm left upper pole renal angiomyolipoma.	Non-contrast chest CT is recommended in 3-6 months.  If the nodules are stable at time of repeat CT, then future CT at 18 - 24 months (from today's scan) is considered optional for low-risk patients, but is recommended for high-risk patients.
2		4A: 10 mm lung nodule	Small coarse calcification in the right thyroid, coronary artery calcifications.	Repeat LDCT in 3 months or PET scan.
3		4X: Multifocal bilateral lung nodules. Most prominent at the right lower lobe nodules with cavitary nodules and spiculated border measuring up to 18 cm. Similar-appearing nodules are probably due to infectious/inflammatory process, but superimposed malignancy is suspected.	None.	Immediate follow-up needed with diagnostic chest CT, PET/CT, or tissue sampling.
4	Lung-RADS 3	Multiple nonspecific bilateral pulmonary nodules measure up to 6 mm.	Indeterminate 1.9 cm right adrenal nodule. Small hiatal hernia.	Repeat LDCT in 6 months – Adrenal protocol CT or MRI with and without contrast.
5		Few nodular densities. Moderate to severe emphysema.	Mild atherosclerotic calcification.	Repeat LDCT in 6 months.
6		Mild ground glass opacities medial portion of the right upper lobe. 6m solid nodule right upper lobe.	Atherosclerotic calcification.	Repeat LDCT in 12 months.
7		Pulmonary nodule, 6 cm	None.	Repeat LDCT in 6 months.
8	Lung-RADS 2	2 solid nodules (< 6mm, < 4mm).	5.7 cm fusiform infrarenal abdominal aortic aneurysm.	Repeat LDCT in 12 months.  Vascular surgical consultation.
9		Scattered subcentimeter nodules, the largest measures 0.2 cm.	None.	Repeat LDCT in 12 months.
10		Few pulmonary nodules measuring less than 6 mm in average dimension including a 5 mm nodule in the left lower lobe.	Mild coronary artery calcification.	Repeat LDCT in 12 months.
11		Few 2 - 3 mm micronodules scattered in both lungs.	Chronic fracture deformities seen in both ribs.	Repeat LDCT in 12 months.
12		Stable right-sided pulmonary nodules	Cardiomegaly with stable small pericardial effusion.	Repeat LDCT in 12 months.
13		2 solid nodules (2 mm, 1mm)	None.	Repeat LDCT in 12 months.
14	Lung-RADS 1	No nodules, moderate emphysema.	Advanced coronary artery calcification.	Repeat LDCT in 12 months.
15		No nodules, mild emphysema.	Mild coronary artery calcification.	Repeat LDCT in 12 months.
16		No nodules, mild centrilobular emphysema.	Moderate hiatal hernia.	Repeat LDCT in 12 months.
17		No suspicious findings	Ascending aorta is aneurysmal measuring up to 4.2 cm. Coronary stents in place.	Repeat LDCT in 12 months.
18		No suspicious findings.	Coronary atherosclerosis.	Repeat LDCT in 12 months.
19		No suspicious findings.	None.	Repeat LDCT in 12 months.
20		No suspicious findings.	None.	Repeat LDCT in 12 months.

Lung-RADS (Lung Imaging Reporting and Data System) standardizes LDCT lung cancer screening results. Scores range from 0 to 4, with higher scores indicating increased cancer risk: 0 (incomplete), 1 (negative), 2 (benign, < 1% cancer risk), 3 (probably benign, 1 - 2%), 4A (suspicious, 5 - 15%), and 4B/4X (highly suspicious, > 15%). This system guides follow-up, with more frequent monitoring or further evaluation for higher scores.

## Conclusions

**Targeted, community-based approaches delivered through virtual-first models can bridge critical gaps in cancer screening by simplifying logistics, reducing costs, and providing tailored support.** Color’s national programs, in collaboration with the American Cancer Society, reached participants across 49 states through telehealth and community-based outreach. This approach enabled personalized navigation and education, particularly benefiting individuals in rural and underserved areas who face barriers to routine cancer screening.

**Lung cancer screening via LDCT not only identified high-risk pulmonary nodules but also revealed incidental findings, offering potential secondary health benefits.** Clinically significant findings (Lung-RADS 3 or 4) were detected in 35% of scanned participants, and many also had incidental findings such as coronary artery calcification or aortic aneurysms, which may prompt earlier intervention for non-cancer conditions.

**Applying ACS screening guidelines in a telehealth setting effectively identified patients with abnormal results and connected them to follow-up care.** Across both programs, participants with abnormal FIT or CT scan results received timely support, including diagnostic referrals and virtual result counseling — demonstrating that telehealth can be a scalable and clinically effective model for cancer screening and care coordination.

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