FOUNDATION FOR
Health Care Quality

2026 Mountain Climber Award Winner Projects

For Excellence in Health Equity

Introduction

In 2022 the Bree Collaborative created an awards program to recognize organizations that are implementing Bree guidelines. Trailblazer awards are given to organizations that demonstrate high fidelity with Bree recommendations and winners are invited to apply the next level - our Mountain Climber award.

The Mountain Climber award is given to organizations that go beyond just implementing best practices and embed equity in to all aspect of their work to ensure that quality care is available and provided to everyone.

Our 2026 awards were given to **UnitedHealthCare** for their work on *Colorectal Cancer Screening*, **Kittitas Valley Healthcare** for their *Outpatient Infection Control* work, and **Molina Healthcare** for their implementation of the Bree's *Complex Discharge* recommendations.

Each of these organizations has shown strong commitments to developing programs and processes that engage communities, identify gaps in care, and address disparities associated with income, age, gender, sexual orientation, geographic location, race, ethnicity, language or disability.

This report summarizes the approaches each organization used to advance equity within its initiative. It highlights how programs were designed and implemented, the strategies used to maintain accountability and address power imbalances and social determinants of health, the challenges encountered and how they were overcome, the methods used to measure success, and the outcomes achieved.

The accomplishments highlighted in this report demonstrate that advancing health equity is both achievable and essential to delivering high-quality care. By intentionally partnering with communities, addressing barriers to care, and embedding equity into organizational practices, these award recipients are creating meaningful and lasting improvements in health outcomes. Their work serves as an example of what is possible when evidence-based care is combined with a commitment to equity.

The Bree Collaborative is proud to recognize these organizations and hopes their experiences will inspire others to innovate, collaborate, and continue building a healthcare system where every person has the opportunity to achieve the best possible health.

FOUNDATION FOR
Health Care Quality

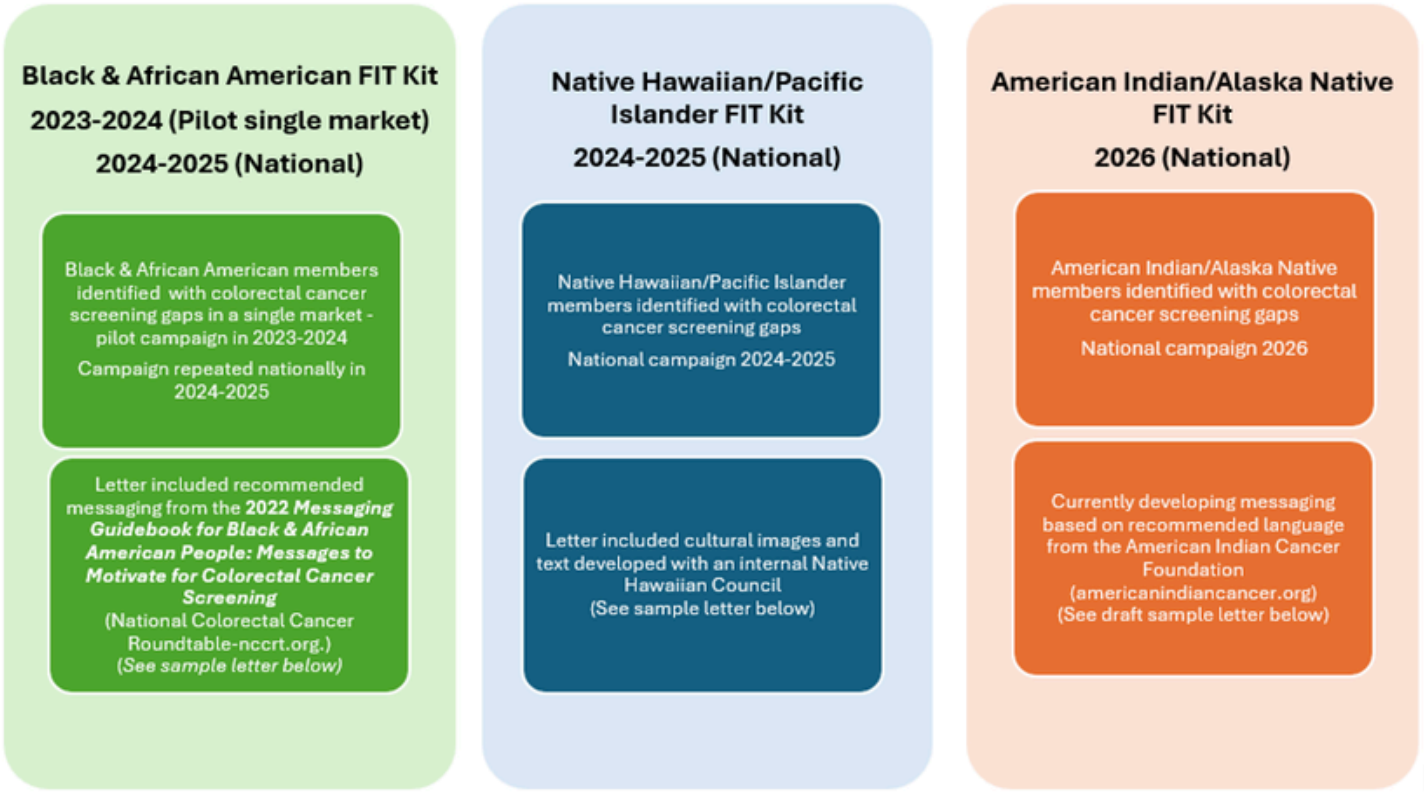
Bree report: Colorectal Cancer Screening

Developing the Project

UnitedHealthcare implemented the Bree Collaborative recommendations to strengthen colorectal cancer screening measurement, reporting, and outreach efforts. UnitedHealthcare enhanced data collection related to colorectal cancer screening participation by capturing demographic information, including race and ethnicity, to support more informed population health strategies. Additionally, the organization tracked and reported colorectal cancer screening rates for eligible adults in alignment with NQF # 0034 and stratified the results by race to better identify and address disparities in preventive care.

In alignment with Bree Collaborative guidance, UnitedHealthcare prioritized outreach and engagement activities for populations with historically lower colorectal cancer screening rates. These efforts supported targeted interventions designed to improve screening participation, reduce gaps in care, and promote equitable access to preventive health services across diverse member populations.

UnitedHealthcare employed the use of member outreach letters that included tailored messaging, and auto-deployment of in-home colon cancer screening kits to prioritized commercial member populations, which included Black and African Americans, Native Hawaiian/Pacific Islanders and American Indian/Alaska Natives. To ensure messaging was culturally appropriate and responsive to community needs, UnitedHealthcare collaborated with key partners, including the American Cancer Society, an Internal Native Hawaiian Council, and the American Indian Cancer Foundation, in the development and review of the outreach materials. Through these efforts, UnitedHealthcare reinforced its commitment to improving preventive care and reducing disparities in colorectal cancer screening.



Maintaining accountability and addressing power imbalances

With the support of the Health Optimization team and other company-wide partners, UnitedHealthCare's quality team has achieved Health Outcomes Accreditation from the National Committee for Quality Assurance (NCQA) in three states. The requirements of these standards have ensured that all employees have the capability and resources to address social drivers of health into their workflows. Additionally, the organization has a Corporate Code of Conduct that all employees must review on an annual basis.

Communication	The organization's Health Optimization Team maintains a SharePoint site where all employees are able to access trainings and updates on company-wide activities relevant to the promotion of health equity.
Education and Training	All employees are able to access a free, on-demand training entitled "Health Equity Foundations" through the company's Intranet. Additionally, all network providers have access to free trainings, including "Delivering Inclusive Care: Cultural Competency and ADA Compliance for Providers" via the organization's online provider portal.
Policies, procedures and activities	The Health Optimization team publishes an annual sustainability report, which focuses on the company's mission of helping people lead healthier lives and make the health system work better for everyone.
Leveraging national initiatives	Collaboration between the quality team and marketing team to leverage monthly campaigns on the portal in accordance with national recognition months such as Black History Month (February); Asian American and Pacific Islander Heritage Month (May); and Native American History Month (November).

In accordance with requirements for NCQA Health Outcomes Accreditation, UnitedHealthCare has implemented policies to address the promotion of health equity. One example is a policy for collection of data using non-stigmatizing methods. These standards provide guidance on how to design questions, type of staff training to support non-stigmatizing data collection, and the frequency and amount of specialized training an individual must complete.

Addressing Social Needs

In the event of a questionable or concerning cancer screening result such as colon polyps, individuals may hesitate to seek further screening due to cost, potentially resulting in a delay in cancer detection. In light of this, UnitedHealthCare implemented a new zero-dollar cost benefit, as highlighted in a March 2026 news release. As of January 1st, 2026, all commercial members will have full coverage for their first preventive colon cancer screening, as well as the first diagnostic screening if applicable. The goal of this is for members to complete cancer risk screenings without the worry of financial risk for additional testing.

Process changes

Health plans, care delivery organizations, clinicians, and electronic health record (EHR) vendors operate with differing incentives, priorities, and technical capabilities, which can create inefficiencies within the prior authorization (PA) process. A more streamlined and effective future-state model can be achieved by focusing on key points in the PA workflow that both drive unnecessary administrative burden and resource utilization and present opportunities for cross-stakeholder collaboration. Targeted improvements in these areas can enhance efficiency, reduce waste, and support a more integrated authorization experience for all participants.

While currently limited to one specific state, a Member Advisory Council was established in 2024. The function of this group is to engage community members in discussions regarding understanding of their benefits, their views on organizational health education programs and perceptions of/experiences with health equity. Additionally, the quality team engages community physicians twice per year through their Medical Advisory Committee meetings. The forum of these meetings is to provide updates on policies and programs within the organization, as well as eliciting feedback on those topics from these individuals to improve the quality of care they provide to their members.

Addressing Barriers

Limited Self-Reported data

Historically, collection of self-reported race, ethnicity, language, sexual orientation, and disability data has been low, especially in the commercial sector. Because employer groups cannot request sensitive information from employees or beneficiaries through enrollment forms, the organization needed to explore alternative avenues to collect the necessary data. Within the past five years, UnitedHealthcare initiated efforts to identify and document race, ethnicity, and language data to meet the requirements of the NCQA HEDIS® Race and Ethnicity Diversity of Membership (RDM) and Language Diversity of Membership (LDM) measures. This involved developing options in the member online portal allowing a member to update their personal data as they wish. Additionally, they are UnitedHealthcare is engaging providers employing electronic medical record systems to expand their systems, which allows for collection of this information at the point of care when seeing a patient.

Budgetary Constraints

In all FIT Kit outreach campaigns between 2023-2025, the quality team auto shipped kits to members in partnership with an outside vendor. Upon review of the quality team's program budget, it was determined that there was low impact for the two national outreach campaigns, given the significant cost associated with a large volume of auto-shipped kits. To improve efficiency and reach a broader population, the quality team changed the 2026 AI/AN FIT Kit campaign to an opt-in option, versus auto-shipping kits. The team estimates that this will allow continued scaling of the program, while reducing waste.

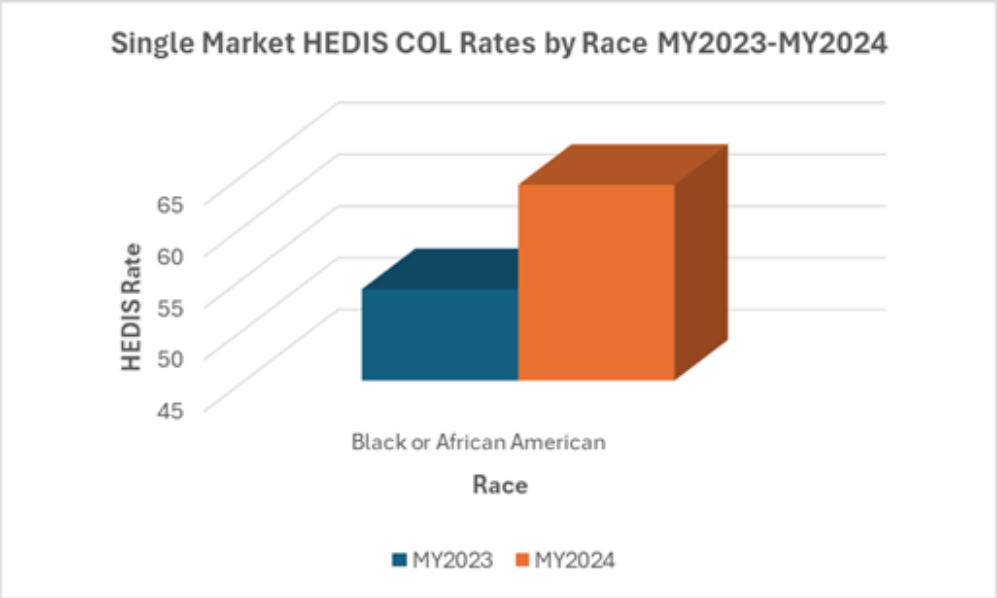
Measuring Success

To evaluate disparities across diverse populations, the quality team applied the Index of Disparity methodology using race and ethnicity classifications established by the Office of Management and Budget (OMB) (www.whitehouse.gov.omb). The Index of Disparity is a nationally recognized and validated measure that quantifies variation among sub-populations by calculating the average difference between the overall population and its constituent groups, resulting in a single measure of disparity. T

his methodology can be applied across various demographic and socioeconomic characteristics, including race, ethnicity, income, and education, and is adaptable to a wide range of performance and outcome measures. Supporting analyses also incorporated supplementary data sources, including indirect demographic data from the U.S. Census Bureau's 2020 Census and Inovalon Prospective reporting.

For each outreach campaign, the quality team established an internal target of achieving a 10% FIT kit return rate by the first quarter of the subsequent calendar year. To assess campaign effectiveness, the team conducted year-over-year (YOY) analyses of the HEDIS® Colorectal Cancer Screening (COL) measure, stratified by race, and evaluated changes in the Index of Disparity. Successful outreach efforts were expected to result in improvements in both COL screening rates and disparity scores among the targeted populations. Performance was benchmarked against the National Committee for Quality Assurance (NCQA) Quality Compass 33rd percentile benchmarks for the COL HEDIS measure to evaluate outcomes relative to industry standards.

The formula to calculate the Index of Disparity is as follows:
ID = (Σ|r(n) – R| / n) / R*100
r = subpopulation rate, R = total population rate, n = number of subpopulations
A Health Index Disparity score greater than 5.0 indicates the existence of a disparity.



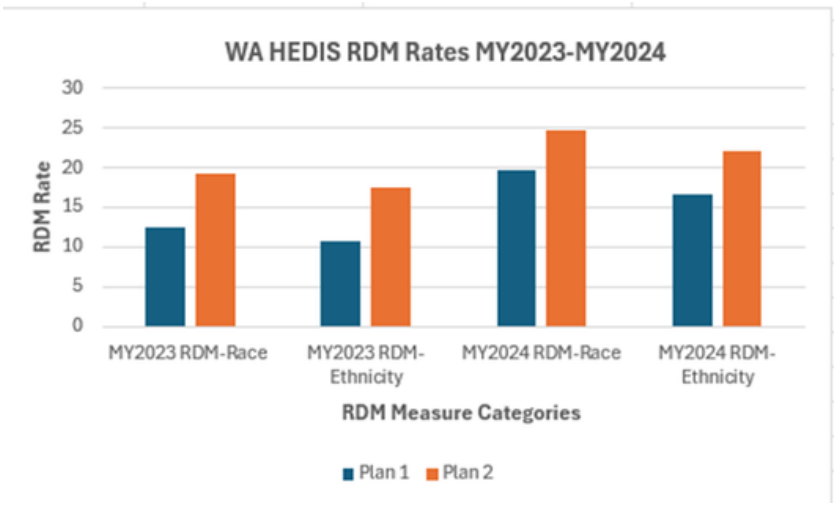
The 10% kit return rate goal was met for the 2023-2024 single market pilot campaign for Black & African Americans.

Measuring Success

Trending from MY2023-MY2024 in this market revealed an improved level of performance for this population with a noted change in disparity to the Native Hawaiian/ Pacific Islander (NH/PI) population as noted in the table to the right. It was this change in disparity that prompted the implementation of the 2024-2025 NH/PI campaign.

Single Market Index of Disparity Trending – Race MY2023-MY2024

Race	MY2023	MY2024
White	67.30%	63.70%
Black or African American	66.60%	63.10%
American Indian or Alaska Native	64.20%	57.60%
Asian	66.70%	63.30%
Native Hawaiian/Pacific Islander	60.10%	58.20%
Some Other Race	60.10%	56.90%
Two or More Races	78.50%	72.80%
Asked But No Answer	70.10%	69.00%
Unknown	62.60%	51.30%
Total	**65.20%**	**57.30%**
Index of Disparity	**6.29**	**10.23**



Based on MY2023-MY2024 YOY increased rates for the RDM HEDIS measure in UnitedHealthCare Washington plans, it is evident that the efforts at improving the ability to capture member self-reported data is proving successful. To achieve full credit for this measure, NCQA requires a minimum score of 20% for each component (20% Race/20% Ethnicity).

In MY2024, UnitedHealthCare did achieve the full 20% score for this measure for "Plan 2" as seen in the graph to the left. And based on projections for MY2025, this trend is expected to continue.

Examples from UnitedHeathCare can be found in Appendix A and B.

Kittitas Valley Healthcare

Bree report: Outpatient Infection Control

Developing the Project

As one of the largest employers in the area, Kittitas Valley Healthcare approached the Outpatient Infection Control recommendations from the standpoint of an employer as well as a health care provider, with a project that focused on ensuring that "IPC measures are equitably distributed across the organization and available to all staff members".

They standardized the on-boarding process to ensure success from the beginning. They also target education and training around different literacy and understanding (i.e. medical background or not). Especially with their TB screening, they ensure culturally appropriate communication. They also ensure ongoing staff development in Employee Health requirements and its impact on infection prevention.

Communication	They started by addressing the leadership team and sharing our "why" to this goal. The leaders were very engaged and supportive of the process. They then communicated to our workforce the plans to increase compliance and why it was important both for our workforce safety, as well as for patients and visitors.
Education and Training	They had educational materials on the different requirements for the Employee Health program and from what agency – Department of Health, OSHA, etc. They had those printed and electronically distributed.
Policies, procedures and activities	They expanded their program to make available the necessary items to have completed – they did this by having flu vaccine drives on all locations, offering respirator fit testing quarterly, etc. In all of this they worked with leaders to ensure it was accessible to their staff, and they discussed with the workforce if they were getting the support they needed.
Access	Employee health utilizes KVH's own Workplace Health to complete many of these services. They work with them to ensure that the services they are providing are in a way that their workforce can access them and have success.

To understand patient/staff need, frontline staff input was received and followed up on to ensure they could remove any barriers to the organizations Outpatient Infection Control goals. They often received questions and responded in a timely manner to allow their workforce to act on the information they need to succeed. They also track the compliance data, which showed a "dip" when something needed to be addressed or improved.

Kittitas works very closely with their public health department. They help with their local DOH vaccine drives and share information out to their staff when DOH is having a vaccine drive. They help their workforce navigate the state vaccine registry (WAIIS) when needed. These partnerships were key to the success of their project.

Early on, they identified knowledge gaps and addressed them through printed materials, online education, and discussions during huddles. Kittitas also uses software that lets them review results by department, leader, role, and other categories to identify gaps. Features of this software include employee health and compliance tracking with automation and reporting. It also provides dashboards and analytics with employee self-service that allow employees to complete tasks and review their records, allowing them to be in control.

Addressing Social Needs

Time and cost were the biggest social needs Kittitas sought to address. Busy schedules, travel times, and costs associated with them were a barrier for many. To do this, Kittitas expanded access to vaccines and respirator fit testing through on site clinics and extended hours to capture different shifts. They also streamlined tracking and reminder systems utilizing our software – allowing email and text notifications, which many staff appreciated. They removed barriers such as cost (they pay for all services) and time (it can be done during work hours).

Overcoming Barriers

Access

"We worked with the clinic to see what they could stretch to provide (i.e. opening at 7am instead of 8am) and then we filled in the gaps – respirator fit testing ourselves, finding community support (i.e. flu vaccine drives). They also started doing some off site flu vaccines and charging us more, which our leadership supported us paying for."

Staff Awareness

"it took us some time to find what worked for our teammates and where they valued seeing that information. We started with putting the data in email announcements and on our intranet page, but we found not everyone was aware. ? We asked leaders to take it to huddles/department meetings. We also did print outs in break rooms."

Cost

"The cost of getting this compliance caught up was going to cost 10s of thousands of dollars. We assessed the cost per item, our gaps, and estimated what the cost would be. We took it to leadership, explained the "why" and they approved the cost!"

Maintaining accountability and addressing power imbalances

Their workforce has equitable access to all requirements, regardless of role, department, if they are on leave or not, etc. Their expectations among the workforce are the same for each person – provider, contracted staff, etc., they focus more on a supportive approach (rather that punitive), emphasizing education, reminders, individual conversations as needed, etc.

Measuring Success

To ensure accurate assessment of equity, we expanded our measurement approach to include all individuals working within our facility, not just direct employees. This included contracted staff, volunteers, etc. We also reviewed compliance data across departments and job titles to identify gaps in participation. By broadening inclusion and examining variation, er were able to better identify disparities and target our outreach efforts.

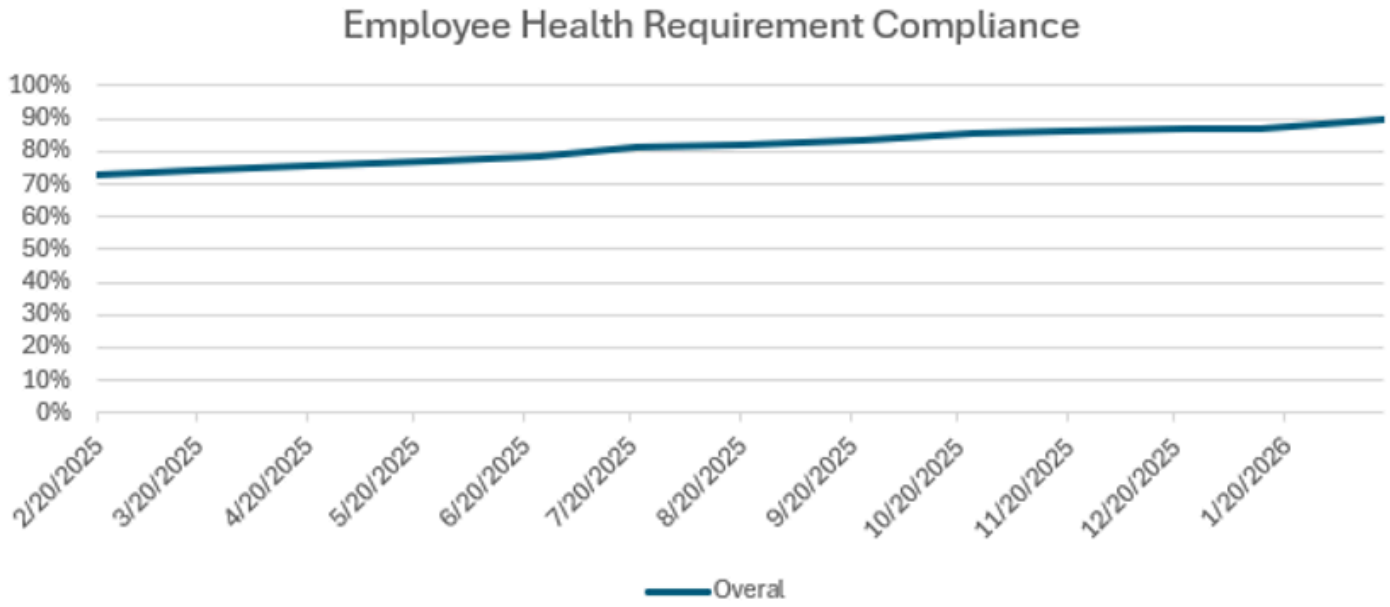
Metrics:

-Overall compliance rates with employee health requirements
-Influenza vaccination rates
-Completion rates for required screenings and immunizations over time

These metrics align with established healthcare quality and safety priorities, particularly those focused on infection prevention, workforce safety, and population health.

Kittitas Valley Healthcare established a benchmark of 100% compliance, so starting on August 10th of 2026, staff will be taken off the schedule if they have not completed the requirements. Employees are given time at work to get the items completed free of cost and they are available at all locations where their workforce works.

Employee Health requirement compliance rates increased from 62% in August of 2024 to 93% in May of 2026. By purchasing the software and being able to be transparent with leaders and workforce on the compliance rates and how to address the gaps, Kittitas Valley Healthcare saw incredible success.



Molina Healthcare

Bree report: Complex Discharge

Developing the Project

Molina Healthcare implemented the Bree Collaborative Complex Discharge Guidelines through the development of a specialized, interdisciplinary Behavioral Health Inpatient Resource Team (BHIRT). This work focuses on members with serious mental illness (SMI) experiencing prolonged or repeated inpatient stays due to complex medical, behavioral health, and social barriers to discharge. Rather than functioning as a passive payer, their organization intentionally redesigned roles, workflows, and partnerships to become an active system partner in complex discharge planning. The program emphasizes:

in person engagement

early identification of discharge barriers

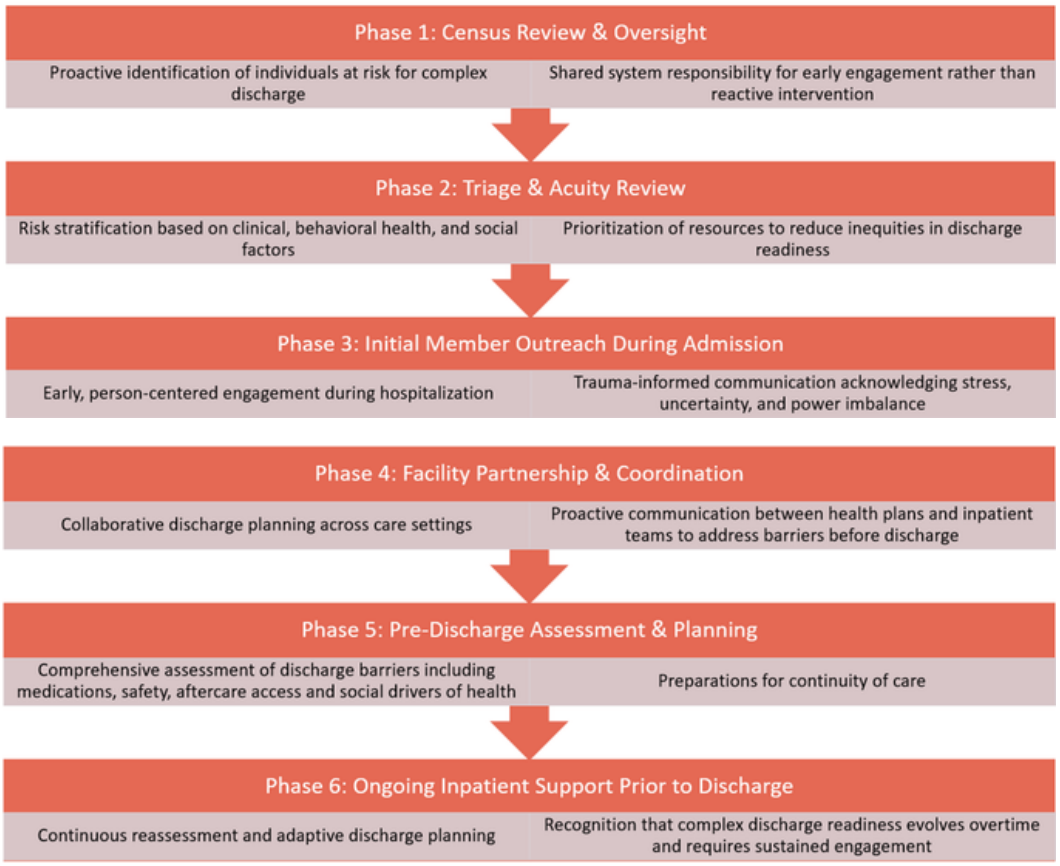
coordinated problem-solving with hospitals, community providers, and members

In addition to relationship-based care, the program is supported by standardized workflows, dashboards, and escalation pathways that promote consistent application of the Bree Complex Discharge recommendations and support accountability, equity monitoring, and continuous refinement as program demand and complexity evolve.

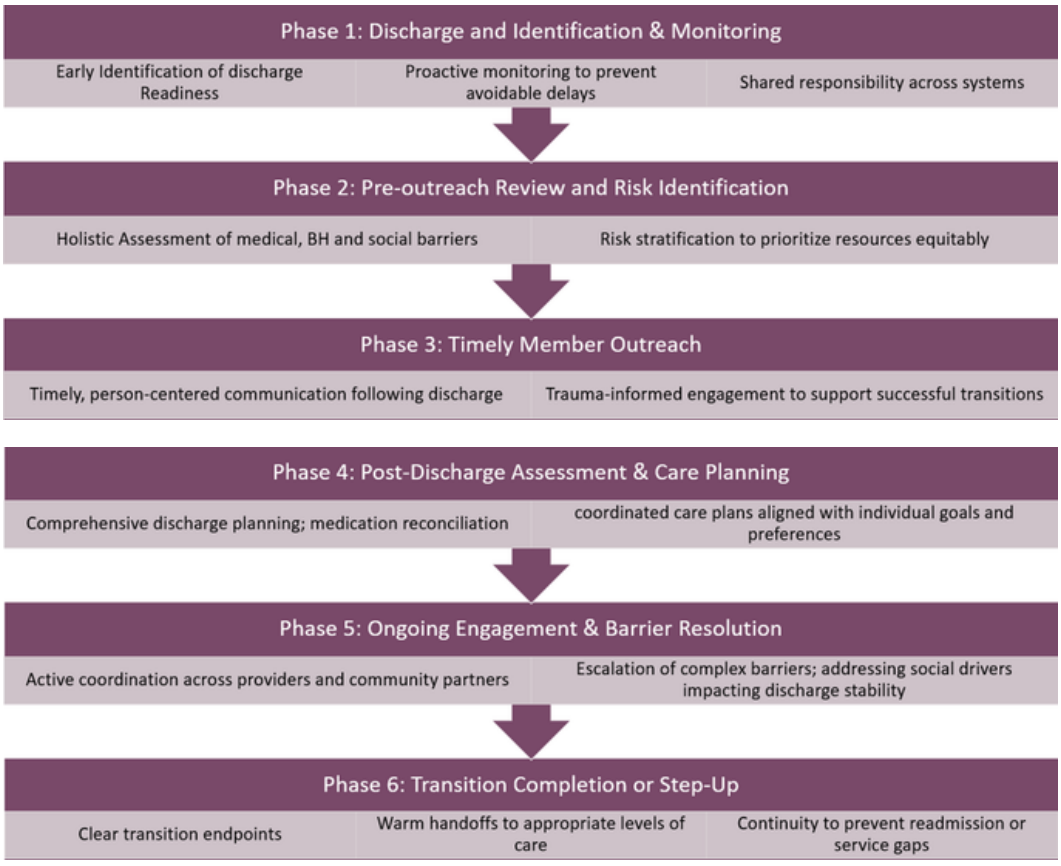
Equity considerations were embedded from the outset, recognizing that members with SMI, particularly those enrolled in Medicaid, experience compounded barriers related to housing instability, transportation, caregiver availability, stigma, and system fragmentation.

As the program matured, success became defined not only by compliance with timelines and documentation, but by the program's ability to deliver reliable, timely, and appropriate services consistently across populations, regardless of acuity, discharge setting, or geography. Ongoing audits and performance reviews support continuous refinement to maintain equity as demand evolves. Strategies include:

- In person assistance with applications and referrals
- Connection to community-based organizations
- Short-term "stopgap" clinical supports when access delays exist
- Community connectors with lived experience and local knowledge



Pre- and post-discharge transitions, demonstrating standardized, yet adaptable processes.



Addressing SDOH and power imbalances

Understanding Patient Needs

Needs are identified through direct, in person engagement with members during inpatient stays and transitions. This approach allows staff to uncover barriers that are often missed through telephonic outreach alone.

Partnerships

Strong partnerships have been developed with:

- Behavioral health hospitals
- Community based organizations
- Housing and social service providers

Addressing Power Imbalance

Empowering patients consists of:

- Meeting members where they are, physically and emotionally
- Honoring lived experience and individual goals
- Positioning the health plan as a partner rather than an authority or gatekeeper

These strategies intentionally redistribute power by centering member-defined needs and positioning the health plan as a partner in problem-solving rather than a gatekeeper of services.

Addressing social drivers of health posed a challenge, requiring deep knowledge of local resources and community connections. This barrier was mitigated by hiring Community Connectors from within the served communities, ensuring staff were culturally and linguistically representative and had established knowledge of local supports. Their community expertise facilitated effective identification of needs and timely referrals to appropriate resources.

Addressing Barriers

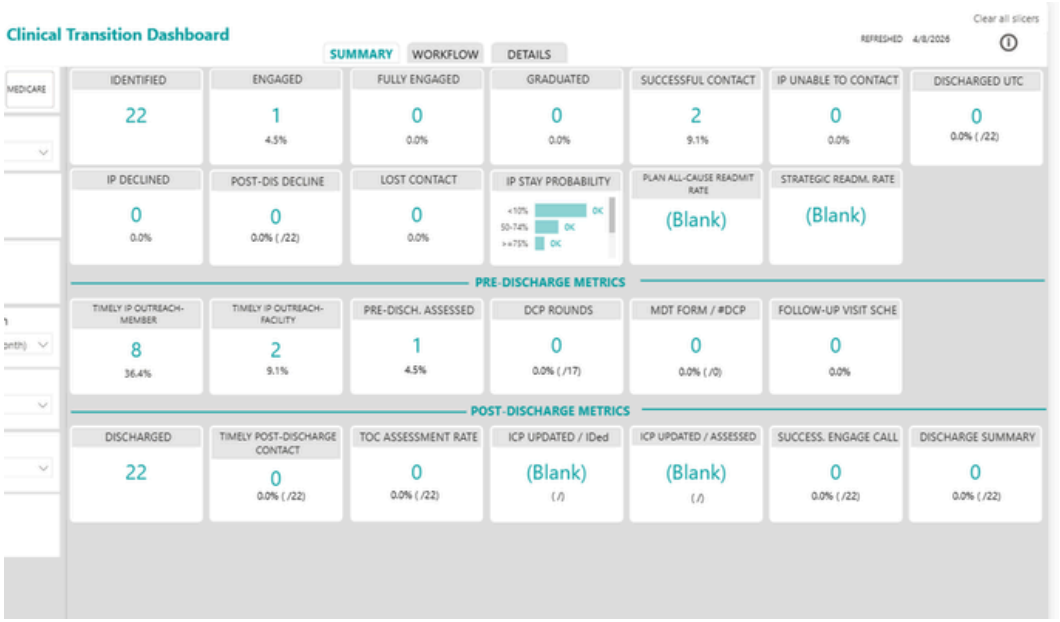
Barrier	How was it identified?	How was it addressed
Difficulty engaging high-need members	Identified through low response rates and repeated hospitalizations	Addressed through in person outreach and relationship building
Housing and placement constraints	Identified through prolonged inpatient stays	Addressed through expanded community partnerships and advocacy
System rigidity and internal change management	Identified through workflow mismatches	Addressed through continuous adaptation and staff feedback loops

Health plan culture change represented a significant implementation barrier, requiring a shift from a primarily telephonic service model to in-person engagement. This transition required changes in staff workflows, expectations, and professional identity. The barrier was addressed through a clear mission shift emphasizing community presence, targeted trainings to support field-based work, and sustained leadership support throughout the transition.

Additionally, ongoing coordination with hospital partners poses a challenge, as high turnover within hospital settings results in a continual need for communication and education about the program. Frequent changes in hospital personnel required repeated orientation on program goals, referral criteria, and workflows. This was mitigated through proactive engagement with hospital leadership, consistent communication, and ongoing education efforts to support program continuity despite staffing variability.

Ensuring Accountability

A dashboard was developed to support accountability, quality improvement, and tracking across key operational metrics. It is reviewed by leadership and key metrics are shared across teams to support the program's success.



What made this a success?

This project's success in embedding equity into complex discharge planning was driven by a combination of culture change, standardized infrastructure, and intentional use of data to reinforce accountability. A significant shift occurred from primarily telephonic care management to an in-person, relationship-based model, allowing staff to identify and address barriers that disproportionately affect members with serious mental illness, housing instability, and limited system trust. Workforce hiring and development emphasized lived experience, community connection, and adaptability, reinforcing an equity-centered culture across the team.

Standardized workflows, dashboards, and escalation pathways enabled consistent application of the Bree Complex Discharge recommendations while allowing flexibility to respond to member-specific needs. Data were used not only to track compliance, but to surface variation, inform escalation, and guide continuous improvement. Behavioral health readmission trends, process measures, and qualitative feedback were reviewed together to ensure that outcomes—and the processes driving them—remained reliable and equitable across acuity levels, geographic regions, and discharge settings.

Measuring Success

The BHIRT program uses process- and outcome-based quality improvement metrics aligned with Bree Collaborative recommendations related to care transitions, behavioral health integration, suicide care, and equity. These metrics emphasize timely access to services, continuity of care, and reliable follow-up, which are core elements of the Bree Complex Discharge Guidelines.

Primary quality improvement metrics include:

1. **Timeliness of outreach following inpatient or emergency department discharge, including contact attempts within required business-day time frames**

Readmission trends were monitored over time using monthly behavioral health readmission data for Medicaid members in Washington. A comparison of July 2025–March 2026 data reflect month-over-month variation in total readmissions, readmission rates, and readmissions per 1,000 members across the measurement period. Several months demonstrated reductions in total readmissions and readmission rates compared to the prior period, while other months reflected expected variability in a high-acuity behavioral health population.

2. **Documentation completeness and timeliness for care coordination and required workflows**

Ongoing program monitoring demonstrates improvements in equitable service delivery, including increased consistency in timely outreach and documentation across member populations, reduced variation between higher- and lower-acuity members, and improved adherence to standardized triage and follow-up workflows.

3. **Appropriate triage and assignment based on clinical acuity**

Identified gaps trigger targeted process-improvement efforts rather than disproportionately affecting specific populations, supporting more consistent and equitable behavioral health transitions of care over time.

4. **Completion of required post-discharge and critical-incident follow-up activities**

Cost and utilization data for a high-cost, high-utilizer population were reviewed pre- and post-intervention over a six-month period to inform program impact assessment and guide continued refinement.

Further information on Projects and Awards

Where will winners present on their projects?

If you are interested in learning more about the "how to" of these projects, the Foundation will be provide opportunities throughout the next year for our award winners to present their work and engage with other organizations.

You can find events on our calendar: https://www.qualityhealth.org/events/month/?tribe_eventcategory=78

Or, to stay up to date on recent offerings from the Bree Collaborative you can sign up for our listserv: https://www.viethconsulting.com/members/memberinfo/quick_signup.php?org_id=FHCQ&mt=P9

Applying for awards

Any organizations that is an audience for Bree reports can apply for awards. Examples of audience types include:

- Health plans
- Health Systems
- Clinicians/Pediatricians/Behavioral Health Providers/Specialists
- Community Based Organizations, Professional Associations and Unions
- Employer/ Health Plan Purchasers/ Self-insured Employers
- Educational institutions/schools
- Hospitals

To apply for a Trailblazer award simply fill out a Bree Score card for the topic of interest and submit it or email it to knicholas@qualityhealth.org. You can find all our score cards in our score card bank. https://www.qualityhealth.org/bree/evaluation/new-score-card-bank/

Winners of Trailblazer awards will automatically be invited to apply for a Mountain Climber award. Invitations are sent out annually in January and submission are due by the following April. Specific due dates will be included in the invitations.

Appendix A: UnitedHealthCare - Sample letters

Sample letter - Black and African Americans

This at-home fecal immunochemical test (FIT) kit gives you a more convenient way to screen for early signs of colorectal cancer—no appointment needed, no need to leave home

Here's why it's important

Did you know that colorectal cancer is the third-leading cause of cancer death in both Black men and women in the United States? Colorectal cancer can be caught early or even prevented through regular screening. Most people should begin screening at age 45.

Colorectal cancer is often a silent disease. Usually there are no symptoms. That's why getting screened is so important. Screening can help prevent colorectal cancer or catch it early when it is easiest to treat.

Sample letter - Native Hawaiian/Pacific Islander

<MemberFirstName> <MemberLastName>
<Address_Line_1>
<Address_Line_2>
<City>, <State> <Zip_Code_5> <Zip_Code_4>

Colorectal cancer screening from the comfort of home

Aloha <Member First Name>,

Colorectal cancer may be caught early when it's easier to treat or even prevented through regular screening. Screening should begin at age 45 for most people. Colorectal cancer is often a silent disease with no symptoms, which is why getting screened is so important. This at-home fecal immunochemical test (FIT) kit gives you a more convenient way to screen for early signs of colorectal cancer—no appointment needed, no need to leave home, no additional cost.

What do I need to do?

1. Use the collection paper to collect a stool sample
2. Scrape the surface of the sample using the tool provided
3. Place the sample inside the FIT kit
4. Mail the kit back to the lab in the prepaid envelope

Results and next steps

Once you've returned your kit, your test results will be mailed to you and the physician you provided. Make sure to follow up with your doctor.

Did you know?
In Hawai'i, Native Hawaiian men (kāne) have the highest death rate from colon cancer among all ethnic groups. While screening can prevent 90% of these cancers, data show that >58% of kāne over age 50 have never been screened[1].

Pū'ali kalo i ka wai 'ole.
"For lack of care one may become ill."

Sample letter - American Indian/Alaska Natives

<MemberFirstName> <MemberLastName>
<Address_Line_1>
<Address_Line_2>
<City>, <State> <Zip_Code_5> <Zip_Code_4>

Get screened from the comfort of home

Dear <MemberFirstName>,

Did you know that colorectal cancer disproportionately affects Native communities and is the second leading cause of cancer death?¹ It often has no symptoms, which is why getting screened is so important – and why the recommended age to start regular screenings is now 45.

Now you can check from the comfort of your home – no appointment needed. A fecal immunochemical test (FIT) kit is available to you as a convenient option, and it can help detect certain cancers early, when they may be easier to treat.

Understanding your options

Your health plan covers several in-person and at-home screening options. While a colonoscopy is still considered the gold standard, at-home FIT or FIT-DNA tests are also effective ways to check for blood or cancer cells in the stool.

Talk with your doctor to see which option is right for you and how you can lower your risk. Also consider talking to your relatives about the importance of early detection and encourage them to get screened.

Order your FIT kit today

Scan the code or visit [redacted] to get started.

Questions?

Call [redacted] is a medical oversight company that works with us to provide your FIT kit. Their care team includes a national network of physicians who offer education and oversight for lab testing, as well as counselors, care coordinators and leading labs across the country.

See all you can do with your digital tools

Download the [redacted] or visit [redacted] to find a network primary care provider, track your claims, update your communication preferences and more.

Appendix B: UnitedHealthCare - Member Coverage Information

UnitedHealthcare expands cancer support for eligible commercial members

March 11, 2026

Sign up to get the latest UnitedHealthcare news

With the prevalence of certain types of cancer continuing to grow, including among younger demographics, early detection can often be a crucial step of the journey because it may improve treatment outcomes and survival rates.

Since the mid-2000s, the number of women with breast cancer diagnoses has been steadily rising.[1] In fact, breast cancer is now the most common type of cancer in the U.S.[2]

By comparison, colorectal cancer diagnoses have increased in people under 50 by more than 1% a year since 2005. In the same age group, colorectal cancer is now the leading cause of cancer deaths, according to new research from the American Cancer Society.[3]

That's why for certain UnitedHealthcare plans eligible members have access to **enhanced cancer detection benefits**, including coverage for the first diagnostic breast imaging and the first diagnostic colorectal cancer detection service — at no additional cost to the member.

The new enhanced cancer detection benefit is part of UnitedHealthcare's efforts to help close gaps in care and improve the consumer experience in health care. Since 2021, UnitedHealth Group has closed **575 million gaps in care (pdf)**.

What is the difference between preventive cancer screenings and diagnostic services?

Often **preventive cancer screenings**, such as routine mammograms or colonoscopies, are performed when there are no symptoms present and are designed to catch cancer early or even before it develops, based on average risk factors. Staying on top of preventive care and screenings is one of the most powerful ways to protect one's health and may improve treatment outcomes and survival rates.[4]

In contrast, **diagnostic services** are often used when symptoms are present, a person has greater risk or a preventive cancer screening reveals something abnormal, helping to confirm or rule out a diagnosis.[4] Diagnostic services may come with out-of-pocket costs for the member.

Routine screenings—it's good to have options

Preventive care, like colon cancer screenings, can really make a difference in your health. The recommended ages for getting routine colorectal screenings are 45–75.

Choose the test that's right for you

Your health plan provides coverage for 4 types of preventive colorectal screening tests—your primary doctor can help you decide depending on your personal comfort level and health history.

Stool-based test

Available 3 ways, these at-home tests check your stool for indicators of colon cancer

Virtual colonoscopy

Uses X-rays and computers to create images of your colon

Flexible sigmoidoscopy

Procedure that checks the lower part of the colon

Colonoscopy

Procedure that checks the rectum and the whole colon

Things to know about at-home stool-based tests

What are the options?

UnitedHealthcare provides preventive coverage for the following stool-based screenings:

- Annual fecal occult blood test (FOBT)
- Annual fecal immunochemical test (FIT)
- Fecal DNA testing—such as Cologuard®—once every 3 years as an alternative option

How does stool-based testing work?

- Your provider will order the testing kit, which would be paid as a preventive service at no cost-share. There is no paperwork for you—you may not purchase the fecal DNA kit on your own and submit the bill.
- In some situations, a follow-up screening colonoscopy may be indicated. Whether this would be covered as preventive or under the medical plan as diagnostic will depend on your provider.

Learn more

For more details on the colon cancer screening options, see the UnitedHealthcare **Coverage Determination Guideline**

Applies to fully insured plans and self-funded plans that follow our standard benefit. Certain plans, such as grandfathered plans or custom self-funded plans, may allow cost-sharing on preventive care services including colorectal screening.

Members who are under age 45 or over age 75 do not qualify for preventive benefits under our Preventive Care Services Coverage Determination Guideline. For these members, cost-sharing would typically apply.

United Healthcare

There for what matters.