From Talk to Transformation

How Collaboration Can Drive Progress Toward Better Health

In 2025, the One Utah Health Collaborative convened dozens of healthcare organizations—payers, providers, clinicians, and community partners—behind a shared commitment to increase colorectal cancer (CRC) screening across the state. Since then, stakeholders have shared best practices, respectfully debated different perspectives, distributed thousands of screening tests, reconsidered coverage and billing policies, launched innovative outreach campaigns, and streamlined clinical workflows. These actions are already reshaping the system, and the anticipated outcomes are clear: fewer cancer deaths, lower total costs, improved patient experience, and the elimination of inaccurate bills that surprise patients.

Healthcare executives participating in the Collaborative chose CRC screening as an early test case for the organization's change model because it meets the criteria of being preventable, high-impact, and measurable. CRC remains the second leading cause of cancer-related death in Utah and nationwide; early detection lifts five-year survival to 90%, yet Utah's screening rate has fallen from 74% in 2020 to below 60% in 2022—a stark reminder that lives are at stake, but we can make a collective difference.

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What is unfolding in Utah is unlike anything seen elsewhere. Payers, providers, and other stakeholders are moving in unison toward shared objectives, a degree of coordination that peers in other states find extraordinary. From workgroups focused on closing coverage gaps and optimizing workflows to statewide home testing campaigns and new performance incentives, the Collaborative is turning shared goals into tangible action.

> "When I tell colleagues that payers and providers are collaborating to simplify screening and surveillance," said Dr. Nate Merriman of **Intermountain Health** during one meeting, "they do not believe me. This kind of collaboration doesn't happen elsewhere—it's a big deal, and we should be proud."

Stakeholders describe the power of this alignment: "It's been really helpful to have the power of this group working on best practices together. To be able to go back to my company and say, 'This isn't required, but other organizations are doing this,' has been really powerful," says Dr. Chris Wood of **Deseret Mutual Benefit Administrators (DMBA)**, a non-profit organization that manages health, welfare, and retirement benefits for thousands of Utahns. Jenny Ayala from **Tanner Clinic** adds, "Being involved in this group has not only inspired us to improve our processes and think creatively but has also empowered me personally. I'm looking forward to making a tangible difference in the Davis and Weber County communities."

The results to date—commitments, distributions, policy changes, innovative outreach, and improved workflows—point toward a future where collaboration delivers what individual efforts cannot: measurable wins, broad engagement, and a model others across the country will want to follow. Below are the principles and themes that show how the Collaborative is proving Utah can be a laboratory of change.

One Utah Health Collaborative

Lesson 1: Empower the doers through leadership buy-in.

When CEOs and senior executives commit to a goal, it signals that this work matters—and that it will stay a priority. The Collaborative's Leadership is made up of CEOs, and they were the ones who selected colorectal cancer screening as a focus area. That decision wasn't just symbolic; it created the foundation for action across organizations.

Gaining buy-in at the executive level ensured it didn't get lost among competing priorities. Every organization has dozens of projects, and many fade over time. Organizational commitment at the top unlocked resources, empowered teams, and made it possible for the "doers" to innovate without hesitancy of losing support. Regular updates to the workgroup kept the initiative front and center, preventing it from becoming "just another project."

At the **University of Utah Health**, for example, the leadership set system-wide goals and convened a steering group, holding each other accountable for identifying barriers and overcoming them. **Intermountain Health** also prioritized a concerted effort, holding retreats and developing shared decision tools. Even where efforts were already in place, participants emphasized that anchoring the work at the executive level prevented it from being deprioritized amid competing initiatives, with the Collaborative's structured cadence and accountability mechanisms reinforcing its sustained prominence.

Lesson 2: Make the invisible visible with shared metrics.

With transparent results, stakeholders can track progress, learn from each other, and stay accountable—not only to ourselves and our partners, but to the public.

This begins with clarity: a common definition of the problem and its importance, followed by identifying an overarching metric (e.g., statewide CRC screening rate) and then developed supporting measures defined through stakeholder dialogue—test-type counts, diagnosis stage, follow-up intervals, coding accuracy, and other barriers.

Each organization should track their own contribution: screening rates, FIT completion, order volumes, and demographic patterns. The Collaborative will aggregate and monitor statewide metrics over time, compare partner results, and benchmarks collective progress.

Common measures and shared data make accountability tangible. By aligning on what success looks like and sharing results openly, we create a culture of learning and continuous improvement.

Lesson 3: Design for the greater good using an ideal model of care.

Reorienting around the bigger picture helps overcome obstacles that demand systematic effort, time, and investment. Placing the patient at the center ensures the design works for real people.

The Collaborative began the initiative by asking what an ideal screening experience would look like—and then worked backward to identify barriers that prevent it. Early discussions centered on "Daniela," a fictitious patient whose imagined journey exposed the gaps and inefficiencies that real patients face. Conversations with payers during a policy-focused workgroup started from a simple premise: coverage policies should never create barriers to prevention. From there, the work became about removing anything that stood between that ideal and reality. This principle has translated into tangible actions. Centering patient choice meant expanding beyond colonoscopy as the sole "gold standard" to offer multiple options—FIT, Cologuard, colonoscopy—supported by shared decision-making tools.

Expanding availability involved opening lower-cost sites such as ambulatory surgery centers (**HCA MountainStar**, **Intermountain Health)** to make screening more accessible and affordable for average risk patients. Easing patient burden included **Molina Healthcare's** in-home visits and mailed FIT kits, **U Health Plan's** A/B testing of outreach strategies to learn what resonates, and simplified scheduling practices adopted by **Regence Blue Cross Blue Shield of Utah** and **Utah Medicaid**.

These examples underscore the community's commitment to remodeling the system rather than patching it—keeping the end in mind and centering on the patient to drive structural change.

Lesson 4: Celebrate shared wins & build momentum.

Success stories don't just mark progress—they create momentum that carries the work forward. Regular peer-to-peer updates to the workgroup have maintained urgency in a crowded landscape of competing priorities. This cadence of communication reinforces accountability and cultivates shared ownership of both challenges and victories.

Sharing concrete achievements feeds that momentum. Operational improvements at **Select Health**, **DMBA**, **U Health Plans**, **PEHP Health & Benefits**, and **Regence Blue Cross Blue Shield of Utah** include re-engineering claims processes to eliminate unintended patient billing, saving individual patients thousands of dollars.

Intermountain Health allows patients to self-order a screening test straight from their website. Inspired by this, the **University of Utah** modeled and built their own on-demand screening website - an example that shows competitors caring more about patients than competitive advantage.

Each example adds to the collective energy: savings from improved claims procedures, responsiveness through on-demand portals, assurance of full preventive benefits, financial incentives, and critical self-examination of policy and process. These successes are celebrated in regular exchanges, creating a feedback loop that galvanizes further action and sustains urgency.

Lesson 5: Organize together, take action personally.

When payers, clinics, hospitals, and clinicians come together around a shared purpose, they can devise solutions that no single organization could achieve alone. Because implementation looks different everywhere, the Collaborative provides a unifying north star—better screening, affordability, and quality—while allowing each partner to chart its own route toward that destination.

To illustrate what this looks like in practice (without prescribing a checklist), some partners have worked across traditional boundaries to address coding issues, such as payers and providers collaborating to fix the translation from a clinician's notes to a payer's reimbursement policy. Others have partnered with laboratory vendors—like

the **University of Utah** working with ARUP—to enable safe mail-back at home kits. Still others have created partnerships such as payers and specialists to expand access to lower-cost ambulatory surgery centers, as seen in efforts by **PEHP** and **Regence Blue Cross Blue Shield of Utah**. "**University of Utah Health** has partnered with **CommonSpirit Health** to make it easier for patients to get important cancer screenings. Through another provider-to-provider collaboration, **U Health** physicians are now performing screening colonoscopies at the **CommonSpirit Holy Cross – Salt Lake Hospital**. This new program is designed to reduce wait times and improve access for patients who need these life-saving screenings.

Individual organizations have pursued their own refinements as well, based on recommendations from each other. **DMBA**, for example, began auditing its policies and workflows against the group consensus of the payers , and it is adopting practices so that colonoscopies are covered as preventive (meaning no cost-sharing with the patient). **Select Health** is working to standardize billing rules for patients under 45 in which screenings are recommended but coverage hasn't been clear. **Utah Medicaid** will be introducing an additional withhold measure to incentivize managed-care organizations to improve screening. These examples underscore how a shared purpose can take distinct forms in different settings—and how collaboration enables progress that no single entity could accomplish alone.

What Comes Next

This initiative shows what collaboration can achieve: dozens of organizations organized behind a preventable, high-impact, measurable problem and are delivering concrete results. These lessons show that obstacles yield when payers, providers, and advocates share a mission and that alignment can replace fragmentation.

Attention now turns to sustainability and structural transformation. The ambition is not a succession of isolated projects but to rebuild the underlying architecture so the work endures, embedding advances into coverage, coding, clinical workflows, and patient navigation.

Accountability and measurement will guide what comes next. Agreed metrics will be collected and published; transparent reporting and periodic review will reveal what endures and what needs refinement. Stakeholders must translate aspiration into practice; the Collaborative becomes steward and sentinel, tracking progress, sounding alarms when momentum stalls, and showing how far Utah has come and must go. Persistent measurement and accountability will realize the promise of fewer deaths, lower costs, better patient experience, and accurate cost-sharing.

Action Areas by Participating Organization

Participating organizations contributed to this initiative in different but complementary ways. To illustrate the range of actions taken, the sections below describe four broad categories of effort that emerged through this work. The table that follows highlights which categories each organization engaged in, reflecting how hospitals, payers, and providers applied shared goals within their own operations. Together, these actions demonstrate the breadth of system-level change enabled through collaboration.

Save People Money

Actions that reduce or eliminate unexpected patient costs. This includes improving coding and claims processing, expanding access to lower-cost sites of care, and making affordable at-home tests easy to obtain. Some efforts also incentivize patients to choose lower-cost screening options.

Reduce System Costs

Actions that lower healthcare spending while maintaining quality, such as promoting non-invasive screening tests for average-risk patients, using lower-cost sites of care, simplifying coverage policies, and reducing administrative burden through improved coding and claims processes.

Support Patient Care

Actions that help patients complete screening successfully. This includes personalized outreach and navigation, proactive identification of high-risk patients, and culturally relevant education to address barriers and improve follow-through.

Empower Clinicians

Actions that support clinicians in recommending and completing appropriate screening, such as education on testing options, prompts in the EMRs, coordination between payers and providers, and clinician financial incentives tied to screening completion.

	Save People Money	Reduce System Costs	Support Patient Care	Empower Clinicians
Aetna			●	
Cigna			●	
DMBA	●	●		
Health Choice Utah	●	●	●	
Molina	●	●	●	●
PEHP	●	●	●	
Regence BCBS	●	●	●	
SelectHealth	●	●	●	●
United Healthcare / Optum Health			●	
U Health Plans	●	●	●	
Utah Medicaid			●	●
CommonSpirit			●	●
HCA MountainStar		●	●	
HCI	●		●	●
Intermountain Health	●	●	●	●
U Health	●	●	●	●
Community Health Centers	●	●	●	●
Granger Medical			●	●
Granite Peaks Gastroenterology			●	●
Ogden Clinic	●	●	●	●
Tanner Clinic	●	●	●	●
Utah Gastroenterology			●	●

Other participating organizations not directly paying for or providing care include the American Cancer Society, Bolder Way Forward, Comagine Health, Health Management Associates, and the Utah Department of Health and Human Services.