Recommended, reimbursed — and still not completed.

A partnership brief on closing the gap between the preventive care that is recommended and the preventive care that actually gets finished — in the safety-net settings where the gap is widest.

THE PITCH IN 30 SECONDS

PROPOSED · IN DEVELOPMENT

PROBLEM	U.S. colorectal-cancer screening sits at **63.5% against a 72.8% target** — and 44.89% in Federally Qualified Health Centers (CY2025 UDS; Michigan 48.74%). The services work; **completion** is what fails.
SOLUTION	A proposed **disease-agnostic completion engine**: it finds who is overdue, removes friction, and drives follow-through, run weekly on a fidelity dashboard. A predictive, explainable model is on the roadmap — not in the first pilot.
EVIDENCE	Every lever is already recommended by the Community Preventive Services Task Force (mailed FIT +16.1pp, reminders +15.3pp, navigation +13.6pp). Honest caveat: real-world gains depend on **implementation fidelity** — STOP CRC averaged ~3.4pp — which this design exists to protect.
COST	**~$90** per additional person screened (Pignone et al., JGIM 2021 benchmark).
THE ASK	One clinic to run a pre-registered **12-month pilot**; partners to scale it. Step one is a 30-minute conversation.

THE PROBLEM — ADOPTION, NOT SCIENCE

~8%
of U.S. adults 35+ receive all 15 high-priority preventive services (Borsky, *Health Affairs* 2018).

63.5% → 72.8%
CRC screening vs. the Healthy People 2030 target — barely off baseline (2023).

44.89%
CRC screening in Federally Qualified Health Centers, CY2025 UDS (Michigan 48.74%) — the gap concentrates here.

WHICH ONE ARE YOU? — DIFFERENT PARTNERS, DIFFERENT VALUE, SAME ENGINE

HEALTH CENTERS / FQHCS

Improve a measure you already report

Host the pilot — raise a UDS/HEDIS measure you already report, inside your existing staffing, with the fidelity discipline that makes outreach reliably land.

FUNDERS / PARTNERS

Fund a cost-effective, scalable model

A disease-agnostic engine at ~$90 per additional person screened, with an equity-stratified design and a path from one site to a network.

RESEARCHERS

Co-design a publishable pilot

A pre-registered stepped-wedge / RE-AIM evaluation with a protocol-first publication — rigor built in, co-authorship on the table. Principal investigator: to be confirmed.

THE PILOT LOOP — THREE CORE PILLARS, AND A THREE-PILLAR ROADMAP

CORE · WHAT THE FIRST SITE RUNS

- Service redesign & friction reduction
- Interoperable data infrastructure — one nightly de-identified 19-column file for the pilot
- Implementation enablement — training so the site runs and sustains it

ROADMAP · AFTER A VALIDATED PILOT, NOT IN THE FIRST PILOT

- Predictive AI, explainable
- Agentic & conversational outreach
- Algorithmic equity & governance

Identify → Rank by transparent rules (days overdue, days since a positive test, prior no-shows) → Reduce friction → Communicate (literacy-tailored) → Escalate (community-health-worker outreach) → Measure, incl. diagnostic follow-up after a positive result. No patient messaging is automated in the first pilot.

THE DEMONSTRATION

A proposed 12-month colorectal-cancer completion pilot.

One Southeast Michigan FQHC below the UDS benchmark, with an outreach function and a quality-improvement sponsor. The site keeps its workflow and its data; HSREP is implementation lead (training, fidelity dashboard, weekly measurement, coordination); an academic partner owns the evaluation independently. Evaluated with RE-AIM against the site's own baseline, pre-registering a benchmarked target above the ~3.4-point STOP CRC average, with a comparison clinic where feasible, a named post-grant sustainability path, and guaranteed diagnostic follow-up. First readout after one full screening cycle (about month six); results published whichever way they go. Disease-agnostic by design — the same loop extends to cervical and breast screening, hypertension, and immunizations.

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An HSREP initiative in development. All designs are illustrative and future-tense; no patient data has been collected. The first pilot runs on transparent rules and existing staff; AI components are a roadmap item. Operational materials will be reviewed by counsel before any launch.

SOURCES — Borsky et al., Health Affairs 2018 · Healthy People 2030 C-07 (2023 baseline) · HRSA Uniform Data System CY2025, national and Michigan, accessed Aug 2026 · CDC Community Guide (median effects) · Coronado et al., STOP CRC, JAMA Internal Medicine 2018 · Pignone et al., JGIM 2021 (mailed-FIT cost).