

Printed from hsraep.org/initiative.html · version dated 23 October 2026 · Prevention Adoption Initiative, an HSREP initiative in development · every tab and question on the page is expanded in this printout.

PROPOSED · IN DEVELOPMENT · SEEKING ITS FIRST HOST CLINIC

HSREP (Health System Resilience and Economic Protection) is an independent public-health research and advocacy platform based in Michigan. This pilot is its first applied project.

— THE GAP BETWEEN CARE RECOMMENDED AND CARE FINISHED

From a recommended test to a finished one.

Health centers already know what gets people screened for colorectal cancer. What fails is follow-through: kits that never come back, and positive results that never reach a colonoscopy. The Prevention Adoption Initiative proposes a weekly routine, run by a clinic's own staff, that closes those gaps.

Why one clinic matters. Health centers served more than 32.7 million patients in 2025, and every one reports the same colorectal screening measure to HRSA; from 2027 a HEDIS measure also counts whether a positive test reached a colonoscopy.

Why execution, not a new method. In the largest health-center trial, one mailed-kit programme moved completion anywhere from -7 to +18 points across 26 clinics, depending on how well each clinic carried it out. This pilot works on the carrying out, and writes down what it takes so another clinic can repeat it.

WE ASK

One Michigan health center to host a 12-month pilot on one completion gap: colorectal screening by default, or one your clinic chooses. A nightly coded export, no names or dates; the code key stays with your IT lead.

YOU GET

A weekly list of who is overdue and why, scripts and training for your staff, and an independent

YOU PAY

For my time, under a written agreement: a feasibility rate for months 1 to 3 (planning range \$8,000 to \$10,000), the full rate from month four if you continue (about \$45,000 to \$60,000 for months 4 to 12). Plus kits, postage, texts and your staff's time, as now.

THE EVALUATION

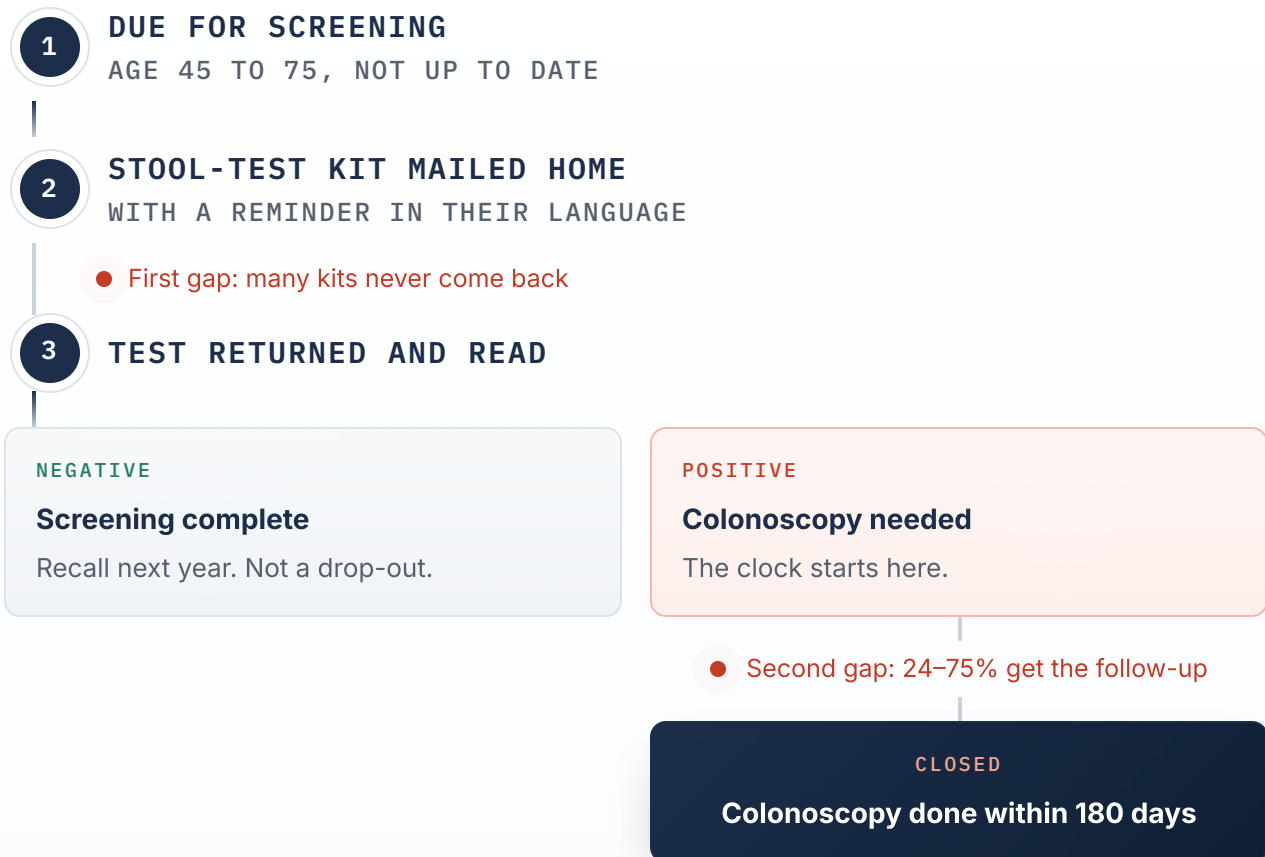
Paid separately, from an academic partner's own grant, once one is confirmed. HSREP itself takes

evaluation of a measure you already report, by an academic partner still to be confirmed. no fee.

Led by **Md Shafaat Ali Choyon**, MBA, MCIM, MPH, CHES®. Seventeen years getting people to follow through, in health care since 2021. [Why I can do this](#)

ONE PATIENT'S PATH

ILLUSTRATIVE



The weekly routine watches both gaps. The 24-75% figure is a reported range across U.S. settings, not one number.

START WITH YOUR PART

The pilot needs three partners. Pick one to see what it would mean for you.

WHAT YOU WOULD COMMIT

Time from your existing outreach staff, sized with you at the start. No new hires. As a working estimate, for a panel of a few hundred overdue patients: five to eight hours a week of outreach staff time in the feasibility phase, 30 minutes a week from your quality-improvement lead, and about half a day, once, from your IT lead to map the file.

A quality-improvement lead who meets with me weekly.

A written agreement before month one: the scope, a feasibility rate for months 1 to 3, and the full rate from month four if you continue.

A decision at month three, with the feasibility measures in front of us: continue, or stop. Nothing is billed after the month you stop.

One nightly export from your IT lead, mapped once: 19 coded columns, no names, record numbers or dates. The list that links codes to patients never leaves your clinic. [Data spec below](#).

Outreach costs: kits, postage and texts.

The money can come from your own budget, a Medicaid plan's quality-incentive dollars, or a grant your clinic holds.

WHAT YOU WOULD GET

About twenty hours a week of hands-on work with your staff in the feasibility phase, and about thirty a week from month four if you continue: scripts that people act on, training, and a next step for every patient who stalls.

A weekly list of who is overdue, and why.

Co-authorship for your quality-improvement lead on what is published, by contribution (ICMJE), and your clinic named only if it chooses.

An independent evaluation of a measure you already report.

No host site or academic partner is confirmed yet. The pilot can start with a host site alone; the independent evaluation needs an academic partner, and without one the result is reported as the clinic's own before-and-after.

YOUR YEAR, IF YOU HOST



BEFORE MONTH 1 • SETUP

What you set up



MONTHS 1-3 • FEASIBILITY

What your staff do

- A 30-minute conversation, then a written agreement: the scope, the two rates, and the decision at month three.
- Name a quality-improvement lead and the outreach staff who will work with me.
- Your IT lead maps the 19 columns once.
- The evaluator measures the starting point and publishes the plan.



MONTH 3 • DECISION

What you decide

- We review the feasibility measures together.
- If the feasibility measures are met, you decide whether to continue to month twelve. If not, we stop. Nothing continues by default, and nothing is billed after the month you stop.

- Make the calls, mail the kits and navigate patients, as now, with me beside them about twenty hours a week.
- Your QI lead gives me 30 minutes a week.
- You cover kits, postage and texts.



MONTHS 4-12 • IF CONTINUED

What you get

- A month 6 readout and a month 12 evaluation, published whichever way they go, with your clinic named only if it chooses.
- A second person on your team trained to keep the list.
- By month twelve your staff run the routine without me. If it did not work, you go back to how you worked before.

RESEARCHER • OWN THE EVALUATION

WHAT YOU WOULD COMMIT

Own the evaluation independently, with IRB approval.

Set the protocol. Working assumption: before and after against the site's own trend, with a comparison clinic where possible, reported with RE-AIM.

Publish the plan before the pilot starts.

WHAT YOU WOULD GET

A real-world completion pilot in a federally qualified health center, and the implementation-science question of how well each step is carried out.

Authorship by contribution, on the ICMJE criteria.

The evaluation is paid from your own grant, not by the clinic or by me. The clinic pays for the implementation.

Still open: the comparison clinic and the target.

YOUR YEAR, IF YOU EVALUATE



What you set

- A 30-minute conversation on the design.
- The protocol: before and after against the site's own trend, a comparison clinic where possible, reported with RE-AIM.
- IRB approval, and an agreement with the clinic for a de-identified evaluation extract.
- A grant for the evaluation, held by your institution. It pays for the evaluation only. The pilot does not wait for it: the clinic's reported screening rate is the starting point you inherit.
- The target, set in advance, and the plan published before the pilot starts.



What you judge

- Your independent read of the feasibility measures goes into the site's decision to continue or stop.

What you watch

- The feasibility measures: kits sent and returned, positives navigated and booked, days from a positive test to a booking, staff hours, file completeness.
- No outcome claims yet. Three months cannot show that rates rose.



What you report

- Month 6: first readout. Month 12: final evaluation against the published target.
- Results published whichever way they go, with authorship by contribution.
- Still open with you: the comparison clinic and the target.

FUNDER • CARRY IT FURTHER

WHAT YOU WOULD COMMIT

Fund one of two things, with a gate at month three. A grant to the host clinic pays for the implementation: my time, materials and outreach. A grant to the academic partner pays for the independent evaluation.

Either way the clinic carries its own staff time. Money for months 4 to 12 is released only if the feasibility measures are met.

Criteria for further investment, agreed before results.

WHAT YOU WOULD GET

A published benchmark to compare against: mailed-kit outreach at \$54.83 direct per patient screened, \$72.90 with overhead, about \$91 per additional person screened once background screening is netted out (Pignone et al., *JGIM* 2021, 2019 dollars). Not the pilot's cost; the feasibility phase measures that.

Results published whichever way they go.

Who this fits: a Medicaid plan's quality-incentive dollars, a Michigan health foundation, or an MDHHS subaward under CRCCP.

YOUR YEAR, IF YOU FUND



BEFORE MONTH 1 • SETUP

What you agree

- A 30-minute conversation.
- The criteria for further investment, agreed before any results exist.
- The application, with the clinic's agreement and, for the evaluation, the evaluator's plan.



MONTH 3 • DECISION

What you decide

- If the feasibility measures are met, months 4 to 12 are released.
- If they are not, nothing more is spent and nothing continues.



MONTHS 1-3 • FEASIBILITY

What you watch

- Only the feasibility phase is spent before the gate.
- You see the published plan and the feasibility measures as they come in.



MONTHS 4-12 • IF CONTINUED

What you get

- A month 6 readout and a month 12 evaluation, published whichever way they go.
- A published benchmark to compare against: mailed-kit outreach at \$54.83 direct per patient screened, \$72.90 with overhead, about \$91 per additional person screened (Pignone 2021, 2019 dollars). Not the pilot's cost; the feasibility phase measures that.
- A routine the site's own staff run after month twelve.

— 01 • THE GAP

Two problems, measured on two different groups.

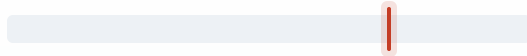
Only about 8% of U.S. adults 35 and older receive all fifteen high-priority preventive services (Borsky et al., *Health Affairs*, 2018). Colorectal cancer screening is the part this pilot takes on. Screening completion counts

everyone who is due. Follow-up counts only people whose test came back positive. They are not steps of one funnel, so this page never multiplies them.

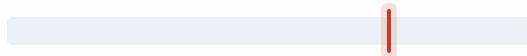
A • UP TO DATE ON COLORECTAL SCREENING

Share of the eligible population

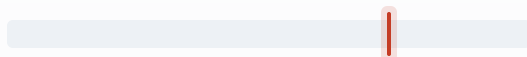
U.S. adults, 2023 (ages 50–75) **63.5%**



Michigan health centers, **48.74%**
CY2025 UDS (45–75)



Federally qualified health **44.89%**
centers, national, CY2025
UDS (45–75)



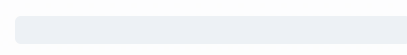
Healthy People 2030 target: 72.8%
(objective C-07, ages 50–75)

Age ranges differ: health-center data (HRSA
UDS) has covered ages 45–75 since 2023.
Close measures, not identical ones.

B • COLONOSCOPY AFTER A POSITIVE STOOL TEST

Share of people who screen
positive

Reported range, **24–75%**
U.S. settings



Shown as a range because
studies disagree. NCQA now
measures it: COF-E, new for
HEDIS MY2027, counts
colonoscopy after a positive
test for ages 45–75 (180
days in the draft
specification; the evaluator
will check the final one
before any formal alignment
is claimed).

Why follow-through, not a new method

In the largest real-world health-center trial (STOP CRC, 26 clinics), the same mailed-kit program moved completion anywhere from –7 to +18 points, +3.4 on average. The main difference was how well each clinic carried it out.

Sources: Borsky et al., *Health Affairs* 2018; Healthy People 2030 C-07; HRSA UDS CY2025 national and Michigan indicators, accessed 3 August 2026; HHS, 2025 Health Center Program data release, 3 August 2026 (more than 32.7 million patients); Coronado et al., *JAMA Internal Medicine* 2018. More in [Evidence and questions](#).

One routine, every week.

Every method in it is already recommended by the Community Preventive Services Task Force. The routine makes sure each step happens for every patient who is due.

01 • FIND • WHO NEEDS ATTENTION?

WHAT HAPPENS

Everyone overdue for a stool test, and every positive test still waiting for a colonoscopy, pulled from the nightly file.

WHO HSREP (me), from your nightly file.

EXAMPLE FROM THE SYNTHETIC WORKLIST

This week: 12 overdue for a stool test, 4 positive tests without a finished colonoscopy. Synthetic panel of 30.

02 • RANK • WHY IS THIS CASE FIRST?

WHAT HAPPENS

Three transparent rules, shown beside every name: days overdue, days since a positive test, prior no-shows. No predictive model in the first pilot.

WHO The rules, in the worklist. Anyone on staff can see why a case is where it is.

EXAMPLE FROM THE SYNTHETIC WORKLIST

Samuel T. • 194 days since a positive test • 1 prior no-show → first in the follow-up queue.

03 • ACT • WHAT SHOULD STAFF DO NEXT?

WHAT HAPPENS

Match the action to the barrier: a mailed kit, a reminder in the patient's language, help booking, or a community health worker.

WHO Your outreach staff, with scripts I write and test with them.

EXAMPLE FROM THE SYNTHETIC WORKLIST

Samuel T. · transport barrier → navigation, plus a ride to the colonoscopy.

04 · CLOSE · WHAT GOT FINISHED?

WHAT HAPPENS

Record the completed test or colonoscopy and the days it took, then check whether follow-up differs between language groups.

WHO Your staff record it. I review the week with your quality-improvement lead.

EXAMPLE FROM THE SYNTHETIC WORKLIST

Follow-up by language: English 3 of 4 · Spanish 1 of 3 · Other 1 of 2.

PILLAR · MAKE FINISHING EASY

At-home test kits by mail, simple scheduling, and help with whatever is in the way.

PILLAR · KNOW WHO IS OVERDUE

From one nightly coded file, I build the weekly list your staff work from. Deeper EHR integration can come later.

PILLAR · TRAIN THE SITE'S STAFF

So the site's own staff can run the routine, and keep running it after the pilot.

Urgent: positive FIT, awaiting colonoscopy

The cohort that decides whether screening saves a life. Sorted by days since the positive result, a live time-to-colonoscopy clock, banded against the 90-day mark CDC's Colorectal Cancer Control Program uses as its quality indicator and the 180-day COF-E follow-up window.⁶ This queue does not exist in most EHRs today.

5 96% on target 96% past best practice 100% fail COF-E COF-E, the follow-up-after-positive measure NQA has proposed for HEDIS MY2027 — colonoscopy within 180 days, ages 45-65.

Samuel T. 64/M - 82 - Ypsilanti N. - Unmeasured 184 days since positive - past the 180-day COF-E window 1 print re-show • Navigate + schedule colonoscopy - navigation + transport	• High Complete colonoscopy ✓
Grace N. 63/F - 0768 - Belleville - Sliding-free 188 days since positive - past 90-day target 1 print re-show • Navigate + schedule colonoscopy - centralized navigation	• Medium Complete colonoscopy ✓
John F. 64/M - 85 - Belleville - Sliding-free 96 days since positive - past 90-day target 1 print re-show • Navigate + schedule colonoscopy - centralized navigation	• Medium Complete colonoscopy ✓
Diane P. 67/F - 88 - Ypsilanti N. - Unmeasured Colonoscopy scheduled - day 14 1 print re-show • Navigate + schedule colonoscopy - centralized navigation	• Routine Complete colonoscopy ✓

Screening queue, overdue for a stool test

Sorted by the date the first pilot would use: days overdue, then prior re-shows. The reason sits beside each name. Language and other barriers never move anyone up the list; they choose the action.

Peter W. 61/M - 0768 - Ypsilanti N. - Unmeasured 930 days overdue 1 print re-show other language... picks the action • Mail FIT kit (language-matched) - via mail	• High Log FIT ✓ Escalate to CHW
Hassan C.	

The screening cascade

Where the panel is right now, and where it looks.

Panel eligible 30
Stool test completed 10
FIT positive 0
96% of positives, the patients check out.

See the worklist

The weekly list I would build from your nightly file and go through with your outreach staff. It supports the routine; the calls and kits are done by people. Thirty invented patients: pick a case, record it as done, and watch the numbers move. No real data, and nothing is sent.

[Open the worklist →](#)

Future capabilities, including any predictive model, come only after a validated pilot. They are set out on the [future roadmap](#).

03 • THE PILOT

Twelve months at one Southeast Michigan health center.

The pilot would suit a health center whose colorectal screening rate is below the national health-center benchmark, with a modern EHR, staff who already do patient outreach, and someone who leads quality improvement. I would reach that clinic through the Michigan Primary Care Association and EMU faculty.

NOT COLORECTAL? • FIVE OTHER FIRST PILOTS

A clinic can choose one of five other gaps as its first pilot instead: the blood pressure recheck, the diabetic eye exam, the diabetic kidney tests, follow-up after an abnormal mammogram, or follow-up after an abnormal Pap or HPV test. One gap per pilot, with extra setup before month one. [The five finish lines, with their published gaps →](#)

SETUP • 1-3
MONTHS

MONTHS 1-3 •
FEASIBILITY

MONTHS 4-12 • FULL
PILOT

DECISION

**Agreement,
starting
point, plan
published**

**Feasibility:
the weekly
routine runs
with the
site's own
staff**

Month 3 ·
decision to
continue, or
stop

**Only if the clinic decides
to continue at month
three**

Month 6 ·
first
readout

Month 12 ·
final
evaluation

**Keep,
scale or
stop.
Nothing
continues
by
default.**

Either way,
by month
twelve your
staff run the
routine
without me.

Three months shows whether the routine can run: kits sent and returned, positive tests navigated and booked, days from a positive test to a booked colonoscopy, staff hours used, and whether the nightly file arrives complete. It cannot show that screening rates rose; that is what months 4 to 12 are for. Milestone timing is proposed. The evaluation milestones assume an academic partner joins before month one, and the protocol is agreed with them.

WHAT I WOULD BE DOING, MONTH BY MONTH

Twenty hours a week to start, thirty from month four. What fills them changes.

I start by doing the work beside your staff, move to teaching it, and end by stepping back. Proposed; the detail is set with your team at the start.



BEFORE MONTH 1 · SETUP

Learning your clinic

- Sit with the outreach staff and the quality-improvement lead to map how a kit goes out and comes back today.
- Agree the 19 columns of the nightly file with your IT lead.
- Draft the first scripts and letters.
- The evaluator publishes the plan.



MONTHS 1-3 · FEASIBILITY

Doing

- About twenty hours a week. Load the file and refresh the list each Monday.
- Sit in on calls with your outreach staff, and work out why each person has not finished.
- Write and test scripts; change the ones that do not land.
- Report to your QI lead weekly. Month 3: we review the feasibility measures and decide together.

Most hours with staff

A few on the file

Teaching

- Your staff run the weekly huddle; I coach rather than lead it, on site once a month and by video in between.
- Train a second person to load the file and keep the list.
- Finish scripts in your patients' languages, with the staff who use them.
- Month 6: first readout with the evaluator, and we fix what it shows.

Hard cases and training Routine now with staff

Stepping back

- Your staff load the file, run the list and the huddle. I watch and fix.
- The routine is written down and handed over.
- Month 12: final evaluation, published whichever way it goes.
- By month twelve your staff run it without me.

Watching and fixing

Staff run it

ONE WEEK, MONTHS 1 TO 3 • ABOUT TWENTY HOURS • ON SITE EVERY OTHER WEEK

MON

Two hours, remote. Nightly file in, refresh the list. Who is new, who is still waiting.

TUE

A full day. On site every other week; by video and phone in between. Thirty minutes with your QI lead, then calls beside the outreach staff.

WED

Three hours, remote. Note why people stalled. Rewrite the script that did not work.

THU

Half a day, remote. Chase the positive tests that still have no booking, with whoever has the list.

FRI

Two hours, remote. Count what moved and what did not. Short note to the QI lead.

The first two weeks are mostly on site. From month four, on site once a month.

HOST SITE

Delivers care

Existing outreach staff make the calls, mail the kits and navigate patients. A quality-improvement lead meets weekly. The site covers kits, postage and texts, and contracts me from month one.

HSREP (ME)

Designs and runs the routine with them

About twenty hours a week in the feasibility phase, thirty from month four. Works the list with staff, matches each follow-up to the reason it stalled, writes and tests the scripts, trains, and fixes what is not working. The data and dashboard are the smallest part. Contracted by the host clinic from month one.

ACADEMIC PARTNER - TO BE CONFIRMED

Judges whether it worked

Before and after against the site's own trend, with a comparison clinic where possible, using RE-AIM. The plan is published first, and the results whichever way they go.

What a host site signs up for

COST TO YOUR SITE

Your clinic contracts me directly, from month one. Months 1 to 3 are a feasibility phase at a reduced rate; from month four, if you continue, the full rate. Both are agreed in writing before month one, and the money can come from your own budget, a Medicaid plan's quality-incentive dollars, or a grant your clinic holds. As a planning range: about \$8,000 to \$10,000 for my time in months 1 to 3, and about \$45,000 to \$60,000 for months 4 to 12 if you continue; the exact figures depend on the hours we agree. Your side is also staff time, kits, postage, texts, and the rides and interpreters you already provide; published mailed-kit

outreach runs about \$55 in direct cost per patient screened (Pignone et al., 2021, 2019 dollars).

MY TIME

About twenty hours a week in the feasibility phase, on site or remote. About thirty hours a week from month four, through month twelve, if you continue.

WHAT I DO EACH WEEK

Most of the week is spent with your team. With your outreach staff I go through the priority list and work out, from what they hear on the calls, why each person has not finished: cost, fear of the procedure, the bowel prep, transport, time off work, or a reminder that never made sense to them. Then we pick the next step that fits that reason. I write and test the reminder scripts and letters in plain language (and in patients' own languages where needed), train staff to use them, and change the routine with your quality-improvement lead when a step is not working. Loading the nightly file and keeping the list and dashboard current takes a few hours a week.

WHAT YOUR STAFF DO

Make the calls, mail the kits and navigate patients, in your own systems, with staff time we size together at baseline. No new hires.

AT MONTH THREE

We review the feasibility measures together. If they are met, you decide whether to continue to month twelve. If not, we stop. Nothing continues by default.

WHAT STAYS WITH YOU

Patient contact, clinical decisions, the key that links codes to patients, and the outreach budget for kits, postage and texts.

IF IT DOES NOT WORK

The site goes back to how it worked before, and the plan and the negative result are published. Your clinic is not named in anything published unless it chooses to be.

IF I CANNOT CONTINUE

The routine is written down as it is built: the list rules, the scripts, the file specification and the weekly huddle. If I become unable to continue, your staff keep running it with what has already been handed

over, payment for my time stops, and the evaluator still reports what happened. The written agreement sets this out before month one.

The data spec is the whole ask of your IT team: 19 coded columns in one nightly file, with dates sent as day counts. No name, MRN, full date of birth, address or phone leaves your system, and the key stays with you. [Field-by-field notes are in the worklist demo.](#)

This page is versioned. This version is dated 23 October 2026; earlier versions are in the [public change history](#). A dated PDF of this version, with every tab and question expanded: [initiative page, 23 October 2026 \(PDF\)](#).

— 04 • TRACK RECORD

The work already done.

Judge the initiative by what exists before the ask.

34%

Screening volume inside a real delivery system

At Praava Health in Bangladesh, as Head of Marketing & Corporate Sales, I redesigned the diagnostic packages and launched Ghore Lab, a home sample-collection service, during COVID. Laboratory screening utilization rose 34% from 2021 to 2022. That was volume and follow-through, not screening completion; the pilot measures completion.

2 countries

A published record

An MPH capstone (Eastern Michigan University) examining health-system fragility and prevention across the U.S. and Bangladesh, published publicly as Season 1's nine-article argument.

57,274

Attention on a \$0 budget

Season 1's advocacy campaign drew 57,274 impressions, summed across three platforms and reconciled to better than 94%, with no ad spend, 5.7× the target set in advance.

Built

The routine, before the ask

The weekly routine, its pillars, the evaluation approach, the worklist demo and the U.S. brief are designed and public. Nothing is deployed.

— WHY I CAN DO THIS

The hard part of this pilot is getting people to finish the test.

The work in this pilot draws on three kinds of skill that clinics usually get from different people: someone who can explain a test so people act on it, someone who knows why people drop out of a service halfway, and someone who can make a weekly routine stick in a busy clinic. I have worked in all three.

HEALTH EDUCATION

Messages people act on

MPH in Health Education & Promotion (Eastern Michigan University) and CHES®. Reminders, letters and call scripts written at the right reading level, and staff trained to use them.

WHY PEOPLE DROP OUT

Seventeen years getting people to follow through

Marketing and growth work, as a Member of the Chartered Institute of Marketing (MCIM), in health care since 2021. At Praava Health in Bangladesh I led the diagnostic-package redesign and the Ghore Lab launch behind the 34% above. During the pandemic, Praava served about 2% of Bangladesh's population, about 3.6 million people, and about 8% of Dhaka's. Part of the work was patient education on which tests people need, so they could test without going through the physician referral commissions common in that market (my own account of the case). Many of the reasons people dropped out there (a price surprise at the next step, urgency that never landed, a second visit that was hard to make) show up in colorectal follow-up too.

OPERATIONS AND DATA

A routine that keeps running

MBA in operations management, and chief operating officer at Laser Treat Group, where I ran the company's ERP, BI and CRM systems. The worklist demo on this site is HSREP's own build.

Md Shafaat Ali Choyon, Founder, HSREP · MBA, MCIM, MPH, CHES®. Your staff know your patients and your community. I know why people stop halfway through a service and what gets them to finish, from seventeen years of doing exactly that. Put together, that is how the routine gets built, and an independent evaluator, once confirmed, judges the result.

WHERE THIS CAME FROM

A pilot proposed from a published, measured argument.

This page is the third step of a thread that began with an article. Each step is public and dated.

Every step is dated and links to the record. The initiative is proposed, not running: an HSREP initiative in development.

[How HSREP works →](#)

— 05 • EVIDENCE AND QUESTIONS

Sources, limits and plain answers.

Sources and methods

The Community Preventive Services Task Force recommends each method, with these median effects on colorectal cancer screening:

METHOD	MEDIAN INCREASE, PERCENTAGE POINTS	PILLAR
Reducing structural barriers (mailed at-home kit)	+16.1	Make finishing easy

METHOD	MEDIAN INCREASE, PERCENTAGE POINTS	PILLAR
Provider reminder and recall	+15.3	Know who is overdue
Patient navigation	+13.6	Train the site's staff
Patient reminders	+11.5 standalone, +10.9 incremental	Know who is overdue

These are published effects in other settings, not the pilot's expected results, and they are not added together. STOP CRC (Coronado et al., *JAMA Internal Medicine* 2018) is the cluster-randomized trial in 26 health centers behind the -7 to +18 point range.

Sources: CDC Community Preventive Services Task Force, colorectal cancer screening findings, accessed 3 August 2026; Borsky et al., *Health Affairs* 2018; Healthy People 2030 objective C-07 (2023 baseline 63.5%, target 72.8%); HRSA Uniform Data System CY2025 national and Michigan performance indicators, accessed 3 August 2026. UDS changed its screening age range from 50–75 to 45–75 beginning CY2023, so years before and after that change are not directly comparable.

How patient data would be handled

The host site remains the covered entity and keeps the key that links codes to patients. The coded nightly file never leaves the host site's systems. It lands in a restricted folder on the site's own secure storage, and I work in it through an account the site issues, under the site's privacy policies. Nothing is copied to HSREP, and the site switches off that access when the pilot ends. The academic partner, once one is confirmed, receives a separate de-identified extract for the evaluation, under its own agreement with the site and its IRB's review. Whether that file, and HSREP's work beside clinic staff, needs a business associate agreement, a limited data set or another arrangement is for the host's privacy officer and counsel to determine. That determination comes before launch, not after.

Consent and outreach run under the site's own policies. Operational materials will be reviewed by counsel before any launch.

What is the Prevention Adoption Gap?

The distance between preventive care that is recommended and reimbursed and the care that is actually completed. The failure is adoption and execution, not the underlying science: people start a preventive pathway far more often than they finish it.

Why track follow-up colonoscopy, not just the screening test?

Because that is where the pathway breaks and where lives are lost. A positive stool test is only a warning; the diagnosis needs a follow-up colonoscopy, and nationally, between **24% and 75%** of positive tests get one. In Italian screening-program data, people who never completed one were about **twice as likely to die** of colorectal cancer (hazard ratio 2.03; Zorzi, *Gut* 2022), and in a 70,124-patient Kaiser Permanente cohort the odds of advanced-stage disease beyond twelve months were more than three times those of a colonoscopy done within a month (Corley, *JAMA* 2017). Both are associations rather than measured causal effects. Most registries mark screening “done” at the stool test; this initiative treats an unresolved positive result as an open, time-critical item, aligned with COF-E, the follow-up measure NCQA has added for HEDIS MY2027 (colonoscopy after a positive test, ages 45–75; 180 days in the draft specification, to be confirmed against the final one). The dashboard demo shows that queue.

Is the colorectal-cancer screening pilot running yet?

No. The pilot is proposed and in development. Nothing has been deployed, and all operational designs shown here are illustrative.

Where would the first pilot run?

The proposed first site is a safety-net setting in Southeast Michigan, chosen because that is where the completion gap is widest and the toolkit can be tested under real constraints.

Is the initiative specific to colorectal cancer?

No. It is a disease-agnostic toolkit for closing preventive-care completion gaps. Colorectal-cancer screening completion is the default first demonstration, and the

only one fully specified today.

Can our clinic pilot a different gap, such as diabetes or blood pressure?

Yes, one gap per pilot. Colorectal screening is ready now. The five gaps on the roadmap (the blood pressure recheck, the diabetic eye exam, the diabetic kidney tests, follow-up after an abnormal mammogram, follow-up after an abnormal cervical result) can be a clinic's first pilot instead, with extra setup before month one: their own data columns, scripts, sign-off from the clinic's clinical lead, and the evaluator, once one is confirmed, agreeing the measure. A clinic can also propose its own gap if it passes four tests: a guideline or quality measure recommends it; whether it is finished shows in the clinic's records; outreach staff, not a clinical decision, can move it; and it is one measure with one finish line. Treatment itself, such as managing an acute emergency or adjusting medication, is outside what the routine does. A pilot on another gap is named for that gap.

How can an organization host or partner on the pilot?

Organizations that own this problem (health systems, safety-net clinics, payers, or public-health agencies) can start a conversation through the platform to host the pilot, partner on it, or fund it.

Who pays for the pilot?

The host clinic contracts the implementation directly, from month one: a feasibility rate for months 1 to 3, and the full rate from month four only if the clinic decides at month three to continue. Both are agreed in writing before the start. As a planning range, that is about \$8,000 to \$10,000 for months 1 to 3 and about \$45,000 to \$60,000 for months 4 to 12; the exact figures depend on the hours agreed. For a funder, that puts the implementation side of a full twelve-month pilot at about \$53,000 to \$70,000, the two ranges together, before the clinic's own outreach costs. The independent evaluation is paid separately, from an academic partner's own grant. Funders can back either side. HSREP itself takes no fee.

Can the pilot start without an academic partner?

Yes. It starts with a host site. An academic partner, still to be confirmed, would run the independent evaluation; without one, the result is reported as the clinic's own

before-and-after on a measure it already reports.

What would an evaluator need from the site?

A monthly completion rate the site already reports, with at least twelve months of it from before the start, so the result is read as an interrupted time series against the site's own trend, with a comparison clinic where one is available. The site needs a panel large enough to read month by month, as a working rule a few hundred patients overdue for screening; the evaluator sets the exact numbers in the published plan. Positive-test follow-ups at one site will be few, so they are reported as counts and days, not as a rate change. Reporting uses RE-AIM.

Does the first pilot use AI?

No. The first site runs the completion loop on transparent rules: days overdue, days since a positive test, prior no-shows. Reminders and navigation are delivered by the site's own staff through its existing channels. A predictive, explainable model and conversational outreach are on the roadmap, to be considered only after a validated pilot, under the site's governance and a BAA. No patient messaging is automated in the first pilot.

How is this different from CDC's Colorectal Cancer Control Program?

CRCCP funds the same evidence-based levers, and this initiative is designed to complement it, not compete with it. CRCCP also monitors how well its sites implement those levers. The difference is the unit of work: STOP CRC showed that results depend on how each step is carried out for each patient, and this initiative adds a clinic-level weekly worklist that shows whether each step happened for each person, matches support to the barrier, treats follow-up after a positive test (the COF-E measure) as the core object rather than an afterthought, and reuses the same engine across diseases. A CRCCP-funded site could run this loop inside its existing award.

What is the Prevention Adoption Initiative?

It is a proposed, disease-agnostic toolkit that closes the gap between recommended and completed preventive care in safety-net settings, beginning with

a colorectal-cancer screening pilot. It is in development; nothing has been deployed.

LIMITATIONS, ALWAYS VISIBLE

This is an HSREP initiative in development. Nothing is deployed and no patient data has been collected.

One site measured before and after cannot rule out changes that would have happened anyway. To make the result believable, the pilot should publish its target in advance (for example, at least 10 points above the site's own trend and above the ~3.4-point STOP CRC average), add a comparison clinic where possible, name who pays for staff time after any grant ends, and make sure every positive test gets its follow-up.

The first three months show whether the routine can run, not whether screening rates rose.

Published effect sizes are not the pilot's expected results.

If your organization owns preventive-care completion, let's talk.

Host the pilot, fund it, or partner on it. Step one is a 30-minute conversation.

OPEN QUESTION № 02 • NO CLOSING DATE

Where does preventive care break down between recommended and completed in your setting?

The Prevention Adoption Gap is the argument on this page. The open question is the same argument put back to the people who watch it happen: colorectal screening reaches 44.89% at the average federally qualified health centre and 48.74% in Michigan, and the reasons are not in the published figures.

Answer from your own setting. Five minutes, under your name and affiliation, read before anything is published, and nothing published without your consent.