Capsule Commentary on Berkowitz et al., Building Equity Improvement into Quality Improvement: Reducing Socioeconomic Disparities in Colorectal Cancer Screening as Part of Population Health Management

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Berkowitz et al.¹ investigated an integrated health information technology (IT) and systemwide population-based intervention to reduce socioeconomic disparities in colorectal cancer (CRC) screening. The authors used non-visit-based, IT surveillance for identifying and tracking patients overdue for screening. Identified patients were contacted by letter or by a scheduler, with or without physician involvement. High-risk patients were given intensive patient navigation. The investigators obtained a 3 % increase in CRC screening overall and modestly reduced screening disparity (by 0.7 %) among those with low educational achievement.

As the population becomes more diverse, it is increasingly important to address health disparities. Although there is evidence for transforming the delivery of care from one-on-one office visits to a patient-centered approach, the most effective and efficient intervention is still unknown. The magnitude of the absolute reduction in disparities in this study is modest, likely due to better high-baseline screening rates at the study location. Nevertheless, from a population health standpoint, it demonstrated overall screening improvement. Also, this study is a proof of concept that both quality and equity can be addressed at the same time in a single intervention.

As the author suggested, this study may not be generalizable to other practices. In addition to education attainment, the disparities in screening could also be due to other factors, such as race, income, insurance type and perception of screening,² which were not explored in this paper. Inequities in CRC screening rates also differ across ethnic groups where

sociocultural factors play an important role in screening. These differences were partially explained by socioeconomic status and access to care, suggesting that disparities will persist unless interventions are tailored to these groups.³

Disparities in health and improvement in overall quality of care may result in cost burden.⁴ Successful large scale application of this intervention requires a multi-faceted approach that includes extensive training of involved personnel, interventions optimized to local workflow needs, and financial models that foster non-visit-based care.^{4, 5} Future studies designed to reduce health inequalities should be formally evaluated using cost-effective analysis.

Conflicts of Interest: The author has no conflicts of interest with this article.

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