Appendixes
Appendix A. Literature Search Strategies

Database: Ovid MEDLINE(R)

Broad search:
1 Healthcare Disparities/
2 "Health Services Needs and Demand"/
3 exp Health Services Accessibility/
4 exp Socioeconomic Factors/
5 Minority Groups/
6 exp Population Groups/
7 vulnerable populations/ or working poor/
8 exp Disabled Persons/
9 exp Sexual Minorities/
10 Minority Health/
11 cultural competency/ or cultural diversity/
12 1 or 2 or 3
13 or/4-11
14 13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
15 12 or 14
16 exp Preventive Health Services/
17 exp Mass Screening/
18 exp Health Promotion/
19 ("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
20 or/16-19
21 exp diabetes mellitus, type 2/ or prediabetic state/
22 exp Cardiovascular Diseases/
23 Aspirin/
24 exp breast neoplasms/ or exp colorectal neoplasms/ or exp lung neoplasms/ or uterine cervical neoplasms/
25 exp Obesity/
26 Smoking/
27 exp "Tobacco Use Cessation"/
28 21 or (22 and 23) or 24 or 25 or 26
29 27 or 28
30 29 and pc.fs.
31 20 or 30
32 15 and 31
33 exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new york city/ or san francisco/
34 ("united states" or "u.s." or alabama or alaska or arizona or arkansas or california or colorado or connecticut or delaware or florida or georgia or hawaii or idaho or illinois or indiana or iowa or kansas or kentucky or louisiana or maine or maryland or massachusetts or michigan or minnesota or mississippi or missouri or montana or nebraska or nevada or "new hampshire" or "new jersey" or "new mexico" or "new york" or "north carolina" or "north dakota" or ohio or
focused search: evidence gaps
1. healthcare disparities/
2. "health services needs and demand"/
3. exp health services accessibility/
4. exp socioeconomic factors/
5. minority groups/
6. exp population groups/
7. vulnerable populations/ or working poor/
8. exp disabled persons/
9. exp sexual minorities/
10. minority health/
11. cultural competency/ or cultural diversity/
12. 1 or 2 or 3
13. or/4-11
14. 13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
15. 12 or 14
16. exp preventive health services/
17. exp mass screening/
18. exp health promotion/
19. ("united states preventive services task force" or "u.s. preventive services task force" or "u.s.p.s.t.f." or "uspstf").ti,ab,kw,au.
20. or/16-19
21. exp diabetes mellitus, type 2/ or prediabetic state/
22. exp cardiovascular diseases/
23. aspirin/
24. exp breast neoplasms/ or exp colorectal neoplasms/ or exp lung neoplasms/ or uterine cervical neoplasms/
25. exp obesity/
26. smoking/
27. exp "tobacco use cessation"/
28. 21 or (22 and 23) or 24 or 25 or 26
29. 27 or 28
30. 29 and pc.fs.
31. 20 or 30
32. 15 and 31
33. exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new york city/ or san francisco/
34. ("united states" or "u.s." or alabama or alaska or arizona or arkansas or california or colorado or connecticut or delaware or florida or georgia or hawaii or idaho or illinois or indiana or iowa or kansas or kentucky or louisiana or maine or maryland or massachusetts or michigan or minnesota or mississippi or missouri or montana or nebraska or nevada or "new hampshire" or "new jersey" or "new mexico" or "new york" or "north carolina" or "north dakota" or ohio or oklahoma or oregon or pennsylvania or "rhode island" or "south carolina" or "south dakota" or tennesee or texas or utah or vermont or virginia or washington or "west virginia" or wisconsin or wyoming).ti,ab,kw.
35. 32 and (33 or 34)
36. "Social Determinants of Health"/
37. 35 or 36
38. 37 and (gap* or limit* or lack* or barrier*).ti,ab.

Focused search: aspirin for colorectal cancer prevention
1 Healthcare Disparities/
2 "Health Services Needs and Demand"/
3 exp Health Services Accessibility/ or health status disparities/ or "social determinants of health"/
4 exp Socioeconomic Factors/
5 Minority Groups/
6 exp Population Groups/
7 vulnerable populations/ or working poor/
8 exp Disabled Persons/
9 exp Sexual Minorities/
10 Minority Health/
11 cultural competency/ or cultural diversity/
12 1 or 2 or 3
13 or/4-11
14 13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
15 12 or 14
16 exp Preventive Health Services/
17 exp Mass Screening/
18 exp Health Promotion/
19 ("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
20 prevent*.ti,ab.
21 or/16-20
22 15 and 21
Focused search: aspirin for cardiovascular disease prevention

Healthcare Disparities/
"Health Services Needs and Demand"/
exp Health Services Accessibility/ or health status disparities/ or "social determinants of health"/
exp Socioeconomic Factors/
Minority Groups/
exp Population Groups/
vulnerable populations/ or working poor/
exp Disabled Persons/
exp Sexual Minorities/
Minority Health/
cultural competency/ or cultural diversity/
1 or 2 or 3
or/4-11
13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
12 or 14
exp Preventive Health Services/
exp Mass Screening/
exp Health Promotion/
("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
prevent*.ti,ab.
or/16-20
15 and 21
exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new orleans/ or new york city/ or philadelphia/ or san francisco/
24 exp africa/ or caribbean region/ or central america/ or latin america/ or canada/ or
greenland/ or mexico/ or south america/ or exp antarctic regions/ or exp arctic regions/ or exp
asia/ or exp europe/ or exp islands/ or exp oceania/
25 22 and 23
26 22 not 24
27 25 or 26
28 Aspirin/
29 (aspirin or "acetylsalicylic acid").ti,ab,kw.
30 exp Cardiovascular Diseases/pc [Prevention & Control]
31 ("cardiovascular disease*" or CVD or (coronary adj3 disease) or (heart adj3 disease) or
(microvascular adj3 disease) or CHD or "myocardial infarction" or stroke).ti,ab,kw.
32 31 and pc.fs.
33 28 or 29 or 30 or 32
34 27 and 33

Focused search: breast cancer screening
1 Healthcare Disparities/
2 "Health Services Needs and Demand="/\n3 exp Health Services Accessibility/ or health status disparities/ or "social determinants of
health="/\n4 exp Socioeconomic Factors/
5 Minority Groups/
6 exp Population Groups/
7 vulnerable populations/ or working poor/
8 exp Disabled Persons/
9 exp Sexual Minorities/
10 Minority Health/
11 cultural competency/ or cultural diversity/
12 1 or 2 or 3
13 or/4-11
14 13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or
undertreat* or under-treat* or access* or disparit* or discrimint*).ti,ab,kw.
15 12 or 14
16 exp Preventive Health Services/
17 exp Mass Screening/
18 exp Health Promotion/
19 ("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force"
or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
20 prevent*.ti,ab.
21 or/16-20
22 15 and 21
23 exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los
angeles/ or new orleans/ or new york city/ or philadelphia/ or san francisco/ (1250310)
24 exp africa/ or caribbean region/ or central america/ or latin america/ or canada/ or
greenland/ or mexico/ or south america/ or exp antarctic regions/ or exp arctic regions/ or exp
asia/ or exp europe/ or exp islands/ or exp oceania/
exp Breast Neoplasms [Prevention & Control]
((breast adj3 cancer) or mammogram or mammography or "clinical breast exam" or (breast
adj3 self)).ti,ab,kw.
exp Mass Screening/
screen*.ti,ab,kw.
(25 or 26) and (27 or 28)
12 and 21 and 29
14 and 21 and 29
30 or 31
23 and 32
32 not 24
33 or 34

Focused search: cervical cancer screening
Healthcare Disparities/
"Health Services Needs and Demand"/
exp Health Services Accessibility/ or health status disparities/ or "social determinants of
health"/
exp Socioeconomic Factors/
Minority Groups/
exp Population Groups/
vulnerable populations/ or working poor/
exp Disabled Persons/
exp Sexual Minorities/
Minority Health/
cultural competency/ or cultural diversity/
1 or 2 or 3
or/4-11
13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or
undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
12 or 14
exp Preventive Health Services/
exp Mass Screening/
exp Health Promotion/
("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force"
or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
prevent*.ti,ab.
or/16-20
15 and 21
exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los
angeles/ or new orleans/ or new york city/ or philadelphia/ or san francisco/
exp africa/ or caribbean region/ or central america/ or latin america/ or canada/ or
greenland/ or mexico/ or south america/ or "antarctic regions"/ or "arctic regions"/ or exp
asia/ or exp europe/ or exp islands/ or exp oceania/
Uterine Cervical Neoplasms/
((cervical or cervix) adj3 cancer).ti,ab,kw.
Focused search: colon cancer screening
1 Healthcare Disparities/
2 "Health Services Needs and Demand"/
3 exp Health Services Accessibility/ or health status disparities/ or "social determinants of health"/
4 exp Socioeconomic Factors/
5 Minority Groups/
6 exp Population Groups/
7 vulnerable populations/ or working poor/
8 exp Disabled Persons/
9 exp Sexual Minorities/
10 Minority Health/
11 cultural competency/ or cultural diversity/
12 1 or 2 or 3
13 or/4-11
14 13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
15 12 or 14
16 exp Preventive Health Services/
17 exp Mass Screening/
18 exp Health Promotion/
19 ("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
20 prevent*.ti,ab.
21 or/16-20
22 15 and 21
23 exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new orleans/ or new york city/ or philadelphia/ or san francisco/ 
24 exp africa/ or caribbean region/ or central america/ or latin america/ or canada/ or greenland/ or mexico/ or south america/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp europe/ or exp islands/ or exp oceania/
25 exp Colorectal Neoplasms/pc [Prevention & Control]
26 (((colon or colorectal) adj3 cancer) or colonoscopy).ti,ab,kw.
27 exp Mass Screening/
28 screen*.ti,ab,kw.
29 (25 or 26) and (27 or 28)
Focused search: diabetes
1 Healthcare Disparities/
2 "Health Services Needs and Demand"/
3 exp Health Services Accessibility/ or health status disparities/ or "social determinants of health"/
4 exp Socioeconomic Factors/
5 Minority Groups/
6 exp Population Groups/
7 vulnerable populations/ or working poor/
8 exp Disabled Persons/
9 exp Sexual Minorities/
10 Minority Health/
11 cultural competency/ or cultural diversity/
12 1 or 2 or 3
13 or/4-11
14 13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
15 12 or 14
16 exp Preventive Health Services/
17 exp Mass Screening/
18 exp Health Promotion/
19 ("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
20 prevent*.ti,ab.
21 or/16-20
22 15 and 21
23 diabetes mellitus, type 2/ or prediabetic state/
24 ("type 2 diabetes" or "diabetes mellitus" or prediabet* or (glucose adj3 test*) or A1c).ti,ab,kw.
25 23 or 24
26 12 and 21 and 25
27 15 and 21 and 24
28 26 or 27
29 exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new orleans/ or new york city/ or philadelphia/ or san francisco/
30 28 and 29
31 exp africa/ or caribbean region/ or central america/ or latin america/ or canada/ or greenland/ or mexico/ or south america/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp europe/ or exp islands/ or exp oceania/
Focused search: healthy diet
1 Healthcare Disparities/
2 "Health Services Needs and Demand"/
3 exp Health Services Accessibility/ or health status disparities/ or "social determinants of health"/
4 exp Socioeconomic Factors/
5 Minority Groups/
6 exp Population Groups/
7 vulnerable populations/ or working poor/
8 exp Disabled Persons/
9 exp Sexual Minorities/
10 Minority Health/
11 cultural competency/ or cultural diversity/
12 1 or 2 or 3
13 or/4-11
14 13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
15 12 or 14
16 exp Preventive Health Services/
17 exp Mass Screening/
18 exp Health Promotion/
19 ("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
20 prevent*.ti,ab.
21 or/16-20
22 15 and 21
23 exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new orleans/ or new york city/ or philadelphia/ or san francisco/
24 exp africa/ or caribbean region/ or central america/ or latin america/ or canada/ or greenland/ or mexico/ or south america/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp europe/ or exp islands/ or exp oceania/
25 exp Diet/
26 exp Diet Therapy/
27 exp Exercise/
28 exp Exercise Therapy/
29 exp Physical Fitness/
30 exp Life Style/
31 (diet or exercise or "physical activity" or lifestyle or "life style").ti,ab,kw.
32 or/25-31
33 counseling/ or directive counseling/ or distance counseling/
34 exp health promotion/ or patient education as topic/
35 Health Education/
36 risk reduction behavior/
Focused search: high blood pressure screening
1 Healthcare Disparities/
2 "Health Services Needs and Demand"/
3 exp Health Services Accessibility/ or health status disparities/ or "social determinants of health"/
4 exp Socioeconomic Factors/
5 Minority Groups/
6 exp Population Groups/
7 vulnerable populations/ or working poor/
8 exp Disabled Persons/
9 exp Sexual Minorities/
10 Minority Health/
11 cultural competency/ or cultural diversity/
12 1 or 2 or 3
13 or/4-11
14 13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
15 12 or 14
16 exp Preventive Health Services/
17 exp Mass Screening/
18 exp Health Promotion/
19 ("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
20 prevent*.ti,ab.
21 or/16-20
22 15 and 21
23 exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new orleans/ or new york city/ or philadelphia/ or san francisco/
24 exp africa/ or caribbean region/ or central america/ or latin america/ or canada/ or greenland/ or mexico/ or south america/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp europe/ or exp islands/ or exp oceania/
25 exp Hypertension/pc [Prevention & Control]
26 (hypertension or "high blood pressure" or systolic or diastolic).ti,ab,kw.
27 Mass Screening/
28 early diagnosis/
29 (screen* or test* or diagnosis).ti,ab,kw.
30 25 or 2
31 or/27-30
32 22 and 30 and 31
Focused search: lung cancer
1 Healthcare Disparities/
2 "Health Services Needs and Demand"/
3 exp Health Services Accessibility/ or health status disparities/ or "social determinants of health"/
4 exp Socioeconomic Factors/
5 Minority Groups/
6 exp Population Groups/
7 vulnerable populations/ or working poor/
8 exp Disabled Persons/
9 exp Sexual Minorities/
10 Minority Health/
11 cultural competency/ or cultural diversity/
12 1 or 2 or 3
13 or/4-11
14 13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
15 12 or 14
16 exp Preventive Health Services/
17 exp Mass Screening/
18 exp Health Promotion/
19 ("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw.
20 prevent*.ti,ab.
21 or/16-20
22 15 and 21
23 exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new orleans/ or new york city/ or philadelphia/ or san francisco/
24 exp africa/ or caribbean region/ or central america/ or latin america/ or canada/ or greenland/ or mexico/ or south america/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp europe/ or exp islands/ or exp oceania/
25 exp Lung Neoplasms/
26 (lung adj2 cancer).ti,ab,kw.
27 ((("small cell" or "non small cell") adj3 lung) and cancer*).ti,ab,kw.
28 or/25-27
29 mass screening/ or mass chest x-ray/
30 exp early diagnosis/
31 (screen* or test* or diagnosis).ti,ab,kw.
32 or/29-31
33 28 and 32
34 33 and 22
35 34 and 23
Focused search: obesity
1  Healthcare Disparities/
2  "Health Services Needs and Demand"
3  exp Health Services Accessibility/ or health status disparities/ or "social determinants of health"
4  exp Socioeconomic Factors/
5  Minority Groups/
6  exp Population Groups/
7  vulnerable populations/ or working poor/
8  exp Disabled Persons/
9  exp Sexual Minorities/
10 Minority Health/
11 cultural competency/ or cultural diversity/
12 1 or 2 or 3
13 or/4-11
14 13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
15 12 or 14
16 exp Preventive Health Services/
17 exp Mass Screening/
18 exp Health Promotion/
19 ("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
20 prevent*.ti,ab.
21 or/16-20
22 15 and 21
23 exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new orleans/ or new york city/ or philadelphia/ or san francisco/
24 exp africa/ or caribbean region/ or central america/ or latin america/ or canada/ or greenland/ or mexico/ or south america/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp europe/ or exp islands/ or exp oceania/
25 exp Obesity/
26 Overweight/
27 exp "Body Weights and Measures"/
28 (obese or obesity or overweight or "body mass" or bmi or weight).ti,ab,kw.
29 or/25-28
30 22 and 29
31 30 and 23
32 30 not 24
33 31 or 32

Focused search: smoking cessation
1  Healthcare Disparities/

A-12
"Health Services Needs and Demand"/
exp Health Services Accessibility/ or health status disparities/ or "social determinants of health"
exp Socioeconomic Factors/
Minority Groups/
exPopulated Groups/
vulnerable populations/ or working poor/
ex Disabled Persons/
ex Sexual Minorities/
Minority Health/
cultural competency/ or cultural diversity/
1 or 2 or 3
or/4-11
13 and (equity or equitable or equal* or fair or parity or unequal* or inequal* or inequit* or undertreat* or under-treat* or access* or disparit* or discriminat*).ti,ab,kw.
12 or 14
ex Preventive Health Services/
ex Mass Screening/
ex Health Promotion/
("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
prevent*.ti,ab.
or/16-20
15 or/16-20
20 15 and 21
21 exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new orleans/ or new york city/ or philadelphia/ or san francisco/
22 exp africa/ or caribbean region/ or central america/ or latin america/ or canada/ or greenland/ or mexico/ or south america/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp europe/ or exp islands/ or exp oceania/
23 smoking cessation/ or smoking reduction/ or "tobacco use cessation"/
Smokers/
ex Smoking/
Tobacco/
(smoker* or smoking or cigarettes or tobacco or nicotine).ti,ab,kw.
or/26-29
30 30 and (cessation or stop* or cease* or reduction).ti,ab,kw.
31 25 or 30
32 22 and 32
33 33 and 23
34 33 not 24
35 34 or 35
36 Systematic reviews:
Healthcare Disparities/
"Health Services Needs and Demand"/
exp Health Services Accessibility/
exp Socioeconomic Factors/
Minority Groups/
exp Population Groups/
vulnerable populations/ or working poor/
exp Disabled Persons/
exp Sexual Minorities/
Minority Health/
cultural competency/ or cultural diversity/
1 or 2 or 3
or/4-11
13 and (equity or equitable or equal* or fair or disparit*).ti,ab,kw.
12 or 14
exp Preventive Health Services/
exp Mass Screening/
exp Health Promotion/
("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force"
or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
or/16-19
exp diabetes mellitus, type 2/ or prediabetic state/
exp Cardiovascular Diseases/
Aspirin/
exp breast neoplasms/ or exp colorectal neoplasms/ or exp lung neoplasms/ or uterine cervical neoplasms/
exp Obesity/
Smoking/
exp "Tobacco Use Cessation"/
21 or (22 and 23) or 24 or 25 or 26
27 or 28
29 and pc.fs.
29 or 30
20 or 30
15 and 31
exp united states/ or baltimore/ or boston/ or chicago/ or "district of columbia"/ or los angeles/ or new york city/ or san francisco/
("united states" or "u.s." or alabama or alaska or arizona or arkansas or california or colorado or connecticut or delaware or florida or georgia or hawaii or idaho or illinois or indiana or iowa or kansas or kentucky or louisiana or maine or maryland or massachusetts or michigan or minnesota or mississippi or missouri or montana or nebraska or nevada or "new hampshire" or "new jersey" or "new mexico" or "new york" or "north carolina" or "north dakota" or ohio or oklahoma or oregon or pennsylvania or "rhode island" or "south carolina" or "south dakota" or tennessee or texas or utah or vermont or virginia or washington or "west virginia" or wisconsin or wyoming).ti,ab,kw.
32 and (33 or 34)
africa/ or caribbean region/ or central america/ or canada/ or greenland/ or mexico/ or south america/ or exp asia/ or exp europe/
35 not 36
limit 37 to (meta analysis or systematic reviews)
(medline or systematic or metaanalysis or "meta analysis").ti,ab.

Database: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations
1  ((health or healthcare or "health care" or care) and (equit* or disparit* or inequal* or accessibilit*)).ti,ab,kw.
2  (socioeconomic or economic or poor or vulnerable or disenfranchis* or (social adj3 class)).ti,ab,kw.
3  (divers* or minorit* or ethnicit* or race or racial or black* or "african american*" or asian* or "native american*" or indian or hispanic or latin*).ti,ab,kw.
4  (disabled or challenged or handicapped).ti,ab,kw.
5  ("sexual adj3 minorit*" or homosexual* or bisexual* or gay* or lesbian* or transgender* or queer or lbg*).ti,ab,kw.
6  ("cultural competency" or "cultural diversity").ti,ab,kw.
7  (preventive or prevention or prevent).ti,ab,kw.
8  screen*.ti,ab,kw.
9  ("United States Preventive Services Task Force" or "U.S. Preventive Services Task Force" or "U.S.P.S.T.F." or "USPSTF").ti,ab,kw,au.
10  or/2-6
11  10 and (equit* or disparit* or inequal* or accessibilit*).ti,ab,kw.
12  1 or 11
13  12 and (7 or 8 or 9)
14  (diabetes or glucose or aspirin or cardiovascular or heart or coronary or "myocardial infarction" or stroke or colorectal or colon or breast or cervical or human papillomavirus or HPV or diet or exercise or "physical activity" or overweight or obese or obesity or metabolic or hypertension or "blood pressure" or lung or tobacco or smoke* or smoking).ti,ab,kw.
15  13 and 14
16  ("united states" or "u.s." or alabama or AL or alaska or AK or arizona or AZ or arkansas or AR or california or CA or Colorado or CO or Connecticut or CT or delaware or DE or florida or FL or georgia or GA or hawaii or HI or Idaho or ID or illinois or IL or indiana or iowa or IA or kansas or KS or kentucky or KY or louisiana or LA).ti,ab,kw,in.
17  (maine or me or maryland or MD or massachusetts or MA or michigan or MI or minnesota or MN or mississippi or MS or missouri or MO or montana or MT or nebraska or NE or nevada or NV or "new hampshire" or NH or "new jersey" or NJ or "new mexico" or NM or "new york" or NY or "north carolina" or NC or "north dakota" or ND).ti,ab,kw,in.
18  (ohio or OH or oklahoma or OK or oregon or pennsylvania or PA or "rhode island" or RI or "south carolina" or SC or "south dakota" or SD or tennesee or TN or texas or TX or utah or UT or vermont or VT or virginia or VA or washington or WA or "west virginia" or WV or wisconsin or WI or wyoming or WY).ti,ab,kw,in.
19  15 and (16 or 17 or 18)
20  limit 19 to english language

Database: PsycINFO 1806 to February Week 1 2018
1  health disparities/ or treatment barriers/
(equit* or disparit* or inequal* or accessibilit*).ti,ab.
exp sociocultural factors/
exp group differences/
minority groups/ or alaska natives/ or american indians/ or asians/ or blacks/ or cultural sensitivity/ or hawaii natives/ or indigenous populations/ or "latinos/latinas"/ or pacific islanders/ or "race and ethnic discrimination"/ or "racial and ethnic groups"/
exp disabilities/
exp gender identity/
exp sexual orientation/
(divers* or minorit* or ethnicit* or race or racial or black* or "african american*" or asian* or "native american*" or indian or hispanic or latin*).ti,ab.
("sexual adj3 minorit*" or homosexual* or bisexual* or gay* or lesbian* or transgender* or queer or lbg*).ti,ab.
(disabled or challenged or handicapped).ti,ab.
(1 or 2) and (or/3-11)
exp health promotion/
exp DIABETES/
exp cardiovascular disorders/
exp ASPIRIN/
exp breast neoplasms/
cancer screening/
exp overweight/
tobacco smoking/ or smoking cessation/
(diabetes or glucose or aspirin or cardiovascular or heart or coronary or "myocardial infarction" or stroke or colorectal or colon or breast or cervical or human papillomavirus or HPV or diet or exercise or "physical activity" or overweight or obese or obesity or metabolic or hypertension or "blood pressure" or lung or tobacco or smoke* or smoking).ti,ab.
or/13-21
12 and 22
("united states" or "u.s." or alabama or AL or alaska or AK or arizona or AZ or arkansas or AR or california or CA or Colorado or CO or Connecticut or CT or delaware or DE or florida or FL or georgia or GA or hawaii or HI or Idaho or ID or illinois or IL or iowa or IA or kansas or KS or kentucky or KY or Louisiana or LA).ti,ab,in.
(maine or ME or maryland or MD or massachusetts or MA or michigan or MI or minnesota or MN or mississippi or MS or missouri or MO or montana or MT or nebraska or NE or Nevada or NV or "new hampshire" or NH or "new jersey" or NJ or "new mexico" or NM or "new york" or NY or "north carolina" or NC or "north dakota" or ND).ti,ab,in.
(o ohio or OH or oklahoma or OK or oregon or pennsylvania or PA or "rhode island" or RI or "south carolina" or SC or "south dakota" or SD or tennessee or TN or texas or TX or utah or UT or vermont or VT or virginia or VA or washington or WA or "west virginia" or WV or wisconsin or WI or wyoming or WY).ti,ab,in.
23 and (24 or 25 or 26)
limit 27 to english language
limit 28 to yr="1996 -Current"

Database: SocINDEX
1  SU health disparities
2  SU socioeconomic factors
3  DE "RACE" OR DE "BLACK race" OR DE "CRIME & race" OR DE "DANCE & race"
   OR DE "ETHNOCENTRISM" OR DE "HEALTH & race" OR DE "MORTALITY & race" OR
   DE "MUSIC & race" OR DE "OCCUPATIONS & race" OR DE "PERSONAL beauty & race"
   OR DE "RACE & social status" OR DE "RACIAL classification" OR DE "RACIAL minorities"
   OR DE "RACIALIZATION"
4  DE "ETHNICITY" OR DE "CHEROKEE (North American people) -- Ethnic identity"
   OR DE "ETHNIC identity of African American women" OR DE "ETHNIC identity of
   Africans" OR DE "ETHNIC identity of Amerasians" OR DE "ETHNIC identity of Arab
   Americans" OR DE "ETHNIC identity of Arabs" OR DE "ETHNIC identity of Armenian
   Americans" OR DE "ETHNIC identity of Asian Americans" OR DE "ETHNIC identity of
   Creoles" OR DE "ETHNIC identity of Cuban Americans" OR DE "ETHNIC identity of
   Dominican Americans" OR DE "ETHNIC identity of East Indian Americans" OR DE
   "ETHNICITY in children" OR DE "ETHNICITY in women" OR DE "HAWAIIANS -- Ethnic
   identity" OR DE "HISPANIC Americans -- Ethnic identity" OR DE "INDIGENOUS peoples --
   Ethnic identity" OR DE "INDIGENOUS peoples of the Americas -- Ethnic identity" OR DE
   "LATIN Americans -- Ethnic identity" OR DE "MAORI (New Zealand people) -- Ethnic
   identity" OR DE "MAYAS -- Ethnic identity" OR DE "MEXICANS -- Ethnic identity" OR DE
   "MULTIGROUP Ethnic Identity Measure" OR DE "NATIVE Americans -- Ethnic identity" OR DE
   "NAVAJO (North American people) -- Ethnic identity" OR DE "PACIFIC Islanders --
   Ethnic identity" OR DE "POLISH Americans -- Ethnic identity" OR DE "PUERTO Ricans --
   Ethnic identity" OR DE "RACIAL identity of blacks" OR DE "RACIAL identity of racially
   mixed people"
5  DE "SEXUAL orientation" OR DE "ASEXUALITY (Human sexuality)" OR DE
   "BISEXUALITY" OR DE "GYNEPHILIA" OR DE "HETEROSEXUALITY" OR DE
   "HOMOSEXUALITY" OR DE "LESBIANISM" OR DE "PANSEXUALITY (Sexual
   orientation)"
6  DE "GENDER identity" OR DE "ANDROGYNOUS identity" OR DE "FEMININE
   identity" OR DE "GENDER identity & clothing" OR DE "GENDER identity in education" OR
   DE "GENDER identity in mass media" OR DE "INTERSEXUAL identity" OR DE
   "MASCULINE identity" OR DE "SEXUAL diversity" OR DE "TRANSGENDER identity" OR
   DE "TRANSGENDERISM" OR DE "TRANSSEXUALISM"
7  DE "LGBT people" OR DE "BEARS (Gay culture)" OR DE "CLOSETED LGBT
   people" OR DE "GAY people" OR DE "LESBIANS" OR DE "LGBT counselors" OR DE
   "LGBT fathers" OR DE "LGBT immigrants" OR DE "LGBT mothers" OR DE "LGBT people
   in the military" OR DE "LGBT people on television" OR DE "LGBT students" OR DE "LGBT
   teachers" OR DE "LGBT youth" OR DE "MASS media & LGBT people" OR DE "MINORITY
   LGBT people" OR DE "MUSLIM LGBT people" OR DE "RURAL LGBT people" OR DE
   "TRANSGENDER people" OR DE "WORKING class LGBT people"
8  AB prevent OR AB prevention OR AB preventive
9  S1 AND S8
10 S2 OR S3 OR S4 OR S5 OR S6 OR S7
11 S1 AND S10
12 S9 OR S11
13 S12 limiters - Date of Publication: 19960101-20181231
### Appendix B. Included Studies List


## Appendix C. Excluded Studies List


4. Aakhus L. Lifeline education program helps patients see the value of access care. Nephrol News Issues. 2009 Aug;23(9):24-6. PMID: 19753930. **Exclusion reason:** Ineligible publication type


6. Abbott LS. The effect of a culturally relevant cardiovascular health promotion program on rural African Americans. Diss Abstr Int. 2017;78(1-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible study design


16. Acton GJ, Carter PA. Health promotion research: addressing the needs of older adults and their caregivers. J Gerontol Nurs. 2006 Feb;32(2):5. PMID: 16502755. **Exclusion reason:** Ineligible publication type


67. Aloma A. Exploring proximal and distal psychosocial stressors influencing the health outcomes of urban American Indians in the Midwest. Diss Abstr Int. 2017;77(12-B(E)):No Pagination Specified. Exclusion reason: Ineligible publication type


93. Anderson R. The role of community-based programs in addressing health disparities as it relates to breast and cervical cancer in african american women: A systematic review of studies. Diss Abstr Int. 2009;69(12-A):4646. **Exclusion reason:** Ineligible study design


95. Andrade Lopez GG. Integrating technology to improve health and well-being in the Latino population. Diss Abstr Int. 2018;79(4-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible study design


105. Anonymous. New national report card shows quality of care has room for improvement in all communities across the country. Qual Lett Healthc Lead. 2004 Jul;16(7):2-6, 1. PMID: 15366537. **Exclusion reason:** Ineligible intervention


108. Anonymous. Study reignites debate on screenings in the ED. ED Manag. 2005 Sep;17(9):103-4. PMID: 16153023. **Exclusion reason:** Ineligible publication type


111. Aponte J, Nickitas DM. Community as client: reaching an underserved urban community and meeting unmet primary health care needs. J Community Health Nurs. 2007;24(3):177-90. PMID: 17650987. **Exclusion reason:** Ineligible publication type


142. Bajwa HA, Rogers LQ. Physical activity barriers and program preferences among indigent internal medicine patients with arthritis. Rehabil Nurs. 2007 Jan-Feb;32(1):31-4, 40. PMID: 17225372. **Exclusion reason:** Ineligible population

144. Baker LC, Chan J. Laws requiring health plans to provide direct access to obstetricians and gynecologists, and use of cancer screening by women. Health Serv Res. 2007 Jun;42(3 Pt 1):990-1007. PMID: 17489900. **Exclusion reason:** Ineligible study design


152. Banks KW. Increasing the effectiveness of automated outreach calls to promote colorectal cancer screening among African Americans. Diss Abstr Int. 2018;79(3-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible publication type


154. Bao Y, Fox SA, Escarce JJ. Socioeconomic and racial/ethnic differences in the discussion of cancer screening: "between-" versus "within-" physician differences. Health Serv Res. 2007 Jun;42(3 Pt 1):950-70. PMID: 17489989. **Exclusion reason:** Ineligible study design


177. Baughn D. Care for the socially disadvantaged: The role of race and gender on the physician-patient relationship and patient outcomes in a safety net primary care clinic. Diss Abstr Int. 2013;74(3-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible publication type


228. Blumenthal DS. "Best science" for the reduction of disparities in cancer. Ethn Dis. 2003;13(3 Suppl 3):S3-67-72. PMID: 14552458. **Exclusion reason:** Ineligible publication type


255. Brittain K. The relationships between cultural identity, family support and influence, colorectal cancer beliefs, and gender and an informed decision regarding colorectal cancer screening among African Americans. Diss Abstr Int. 2011;71(11-B):6687. **Exclusion reason:** Ineligible study design


264. Brown T, Platt S, Amos A. Equity impact of population-level interventions and policies to reduce smoking in adults: a systematic review. Drug Alcohol Depend. 2014 May 01;138:7-16. doi: 10.1016/j.drugalcdep.2014.03.001. PMID: 24674707. **Exclusion reason:** Systematic review used to identify primary studies


289. Caldwell JT. Rurality and race: Inequities in access to five types of healthcare services. Diss Abstr Int. 2016;76(9-B(E)):No Pagination Specified. Exclusion reason: Ineligible publication type


329. Check W. Too early to solve Pap device puzzle. CAP Today. 1997 Jun;11(6):1, 44-6, 8-9 passim. PMID: 10174227. **Exclusion reason:** Ineligible publication type


371. Consedine NS, Magai C, Neugut AI. The contribution of emotional characteristics to breast cancer screening among women from six ethnic groups. Prev Med. 2004 Jan;38(1):64-77. PMID: 14672643. **Exclusion reason:** Background information only


C-36


516. Facione NC. Breast cancer screening in relation to access to health services. Oncol Nurs Forum. 1999 May;26(4):689-96. PMID: 10337647. **Exclusion reason:** Ineligible study design

517. Facione NC, Facione PA. Perceived prejudice in healthcare and women's health protective behavior. Nurs Res. 2007 May-Jun;56(3):175-84. PMID: 17495753. **Exclusion reason:** Ineligible study design


566. Friedemann-Sanchez G, Griffin JM, Partin MR. Gender differences in colorectal cancer screening barriers and information needs. Health Expect. 2007 Jun;10(2):148-60. PMID: 17524008. **Exclusion reason:** Background information only


585. George SA. Barriers to breast cancer screening: an integrative review. Health Care Women Int. 2000 Jan-Feb;21(1):53-65. PMID: 11022449. **Exclusion reason:** Ineligible publication type


595. Glenn B, Bastani R, Reuben D. How important are psychosocial predictors of mammography receipt among older women when immediate access is provided via onsite service? Am J Health Promot. 2006 Mar-Apr;20(4):237-46. PMID: 16562348. **Exclusion reason:** Ineligible outcome


615. Greenberg LM. A pilot randomized controlled trial comparing the efficacy of problem-solving therapy to enhanced treatment as usual for reducing high blood pressure. Diss Abstr Int. 2016;76(11-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible population


627. Gundersen DA. Examining heterogeneity in the Latino population’s smoking cessation behaviors: The role of language, immigrant generation, and tobacco control context. Diss Abstr Int. 2012;73(5-B):2862. **Exclusion reason:** Ineligible publication type


644. Hasson RE. Do metabolic and psychosocial responses to exercise explain ethnic/racial disparities in insulin resistance? Diss Abstr Int. 2009;70(6-B):3462. **Exclusion reason:** Ineligible publication type


651. Hermosura AHPPo. The relationship between perceived racism and cardiovascular reactivity and recovery in native Hawaiians. Diss Abstr Int. 2015;76(1-B(E)):No Pagination Specified. Exclusion reason: Ineligible publication type


720. Ko ML. Colorectal cancer screening behaviors among korean americans. Diss Abstr Int. 2014;75(4-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible publication type.


744. LaHousse SF. Factors associated with mammography screening utilization among latinas: A revision of the behavioral model of health services use. Diss Abstr Int. 2010;70(7-B):4469. **Exclusion reason:** Ineligible publication type


C-56


776. Lee NC. The unequal cancer burden. Efforts of the Centers for Disease Control and Prevention to bridge the gap through public health. Cancer. 2001 Jan 01;91(1 Suppl):199-204. PMID: 11148579. **Exclusion reason:** Ineligible publication type


May FP. Black-White disparities in colorectal cancer incidence, screening, and outcomes. Diss Abstr Int. 2016;76(9-B(E)):No Pagination Specified. Exclusion reason: Ineligible study design


859. McCall-Hosenfeld JS, Weisman CS. Receipt of preventive counseling among reproductive-aged women in rural and urban communities. Rural & Remote Health. 2011;11(1):1617. PMID: 21280972. **Exclusion reason:** Background information only


865. McDonald CJ. The American Cancer Society addressing disparities and the disproportionate burden of cancer. Cancer. 2001 Jan 01;91(1 Suppl):195-8. PMID: 11148578. **Exclusion reason:** Ineligible publication type


885. McKinney M. Extreme disparities: access to care, health literacy blamed for gaps. Mod Healthcare. 2012 May 21;42(21):17. PMID: 22741480. **Exclusion reason:** Ineligible publication type

886. McLe llan DL, Kaufman NJ. Examining the effects of tobacco control policy on low socioeconomic status women and girls: an initiative of the Tobacco Research Network on Disparities (TReND). J Epidemiol Community Health. 2006 Sep;60 Suppl 2:5-6. PMID: 17708004. **Exclusion reason:** Ineligible publication type


892. McNutt MD. Examining weight gain in treatment-seeking African American smokers: A biopsychosocial approach. Diss Abstr Int. 2017;78(3-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible outcome


908. Meredith LS, Griffith-Forge N. The road to eliminating disparities in health care. Med Care. 2002 Sep;40(9):729-31. PMID: 12218763. **Exclusion reason:** Ineligible publication type


Minich L. Quality of diabetes care: Linking processes to outcomes. Diss Abstr Int. 2011;72(3-B):1801. **Exclusion reason:** Ineligible population

Minor DS, Wofford MR, Jones DW. Racial and ethnic differences in hypertension. Current Atherosclerosis Reports. 2008 Apr;10(2):121-7. PMID: 18417066. **Exclusion reason:** Ineligible publication type


Miser WF. The management of type 2 diabetes mellitus focus on quality. Primary Care: Clinics in Office Practice. 2007 Mar;34(1):1-38. PMID: 17481983. **Exclusion reason:** Ineligible outcome


942. Mohamad Baba Z. Examining disparities in breast cancer screening rates in a program designed to provide free care to women in the state of Pennsylvania. Diss Abstr Int. 2017;78(5-B(E)):No Pagination Specified. Exclusion reason: Ineligible study design


951. Morris AM. Medicare policy and colorectal cancer screening: will changing access change outcomes? JAMA. 2006 Dec 20;296(23):2855-6. PMID: 17179464. **Exclusion reason:** Ineligible publication type


958. Moser K, Patnick J, Beral V. Inequalities in reported use of breast and cervical screening in Great Britain: analysis of cross sectional survey data. BMJ. 2009 Jun 16;338:b2025. doi: 10.1136/bmj.b2025. PMID: 19531549. **Exclusion reason:** Ineligible study design


Mynatt CS. The message is in the world-H.O.P.E.: A spiritually-based cardiovascular disease intervention program. Diss Abstr Int. 2015;76(4-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible publication type


1017. Obisesan O. An examination of the uptake of the Pap smear test among African women immigrants in the United States: A secondary data analysis of the National Health Interview Survey. Diss Abstr Int. 2017;77(10-A(E)):No Pagination Specified. **Exclusion reason:** Ineligible study design


1029. Ojinnaka CO. Rural-urban disparities in stage at diagnosis and treatment of breast cancer and the influence of geographical level characteristics. Diss Abstr Int. 2018;78(9-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible publication type


1051. Palmer RC, Schneider EC. Social disparities across the continuum of colorectal cancer: a systematic review. Cancer Causes Control. 2005 Feb;16(1):55-61. PMID: 15750858. **Exclusion reason:** Systematic review used to identify primary studies


1075. Peltier AE. Addressing cervical cancer disparities among American Indian women: Implementing an educational module for healthcare providers. Diss Abstr Int. 2016;76(8-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible study design


1097. Pomeranz JL, Yang YT. The affordable care act and state coverage of clinical preventive health services for working-age adults. J Public Health Manag Pract. 2015 Jan-Feb;21(1):87-95. doi: 10.1097/PHH.0000000000000102. PMID: 24787498. **Exclusion reason:** Ineligible publication type


1103. Pullen E, Perry B, Oser C. African American women's preventative care usage: the role of social support and racial experiences and attitudes. Sociol Health Illn. 2014 Sep;36(7):1037-53. doi: 10.1111/1467-9566.12141. PMID: 24749849. **Exclusion reason:** Ineligible study design


1105. Quiñones AR, O'Neil M, Saha S, et al. VA Evidence-based Synthesis Program Reports. Interventions to Improve Minority Health Care and Reduce Racial and Ethnic Disparities. Washington (DC): Department of Veterans Affairs (US); 2011. **Exclusion reason:** Background information only


1121. Rees CA. Patient and provider factors, patient-reported racial/ethnic discrimination in the healthcare setting, and quality of care in the diabetes study of Northern California (distance). Diss Abstr Int. 2011;71(10-B):6074. **Exclusion reason:** Ineligible publication type


1124. Reschovsky JD, Boukus ER. Modest and uneven: physician efforts to reduce racial and ethnic disparities. Issue Brief/Center for Studying Health System Change. 2010 Feb(130):1-6. PMID: 20201157. Exclusion reason: Background information only


1218. Sultan-Khan LP. African American women's online evaluation of the breast cancer awareness and prevention portal of the www.DIVAhealth.org website: Using personal-level data and website ratings to tailor and improve the portal. Diss Abstr Int. 2011;71(10-A):3546. **Exclusion reason:** Ineligible study design


1240. Talaat N. Adherence and barriers to colorectal cancer screening varies among Arab Americans from different countries of origin. Arab J Gastroenterol. 2015 Sep-Dec;16(3-4):116-20. doi: 10.1016/j.ajg.2015.07.003. PMID: 26227207. **Exclusion reason:** Ineligible study design


1252. Tao AK. Knowledge, perceived barriers and preventive behaviors associated with cardiovascular disease among Gallaudet University employees. Diss Abstr Int. 2018;79(7-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible study design


1296. Thompson SE, Smith BA, Bybee RF. Factors influencing participation in worksite wellness programs among minority and underserved populations. Fam Community Health. 2005 Jul-Sep;28(3):267-73. PMID: 15958884. **Exclusion reason:** Ineligible publication type


1317. Toney ED. Colorectal cancer screening: Racial/ethnic and gender disparities in a population-based cross-sectional analysis of the United States. Diss Abstr Int. 2007;68(4-B):2303. **Exclusion reason:** Ineligible publication type


1326. Torres SE. The adaptation of a survivorship care plan for low-income colorectal cancer survivors. Diss Abstr Int. 2015;75(9-B(E)):No Pagination Specified. Exclusion reason: Ineligible population


1334. Travis CB, Compton JD. Feminism and health in the Decade of Behavior. Psychol Women Q. 2001 Dec;25(4):312-23. doi: 10.1111/1471-6402.00031. **Exclusion reason:** Ineligible publication type

1335. Traylor AH. Racial and ethnic differences in cardiovascular disease medication management for patients with diabetes. Diss Abstr Int. 2011;72(5-B):2737. **Exclusion reason:** Ineligible population


1354. Tsai JH, Petrescu-Prahova M. Community Interagency Connections for Immigrant Worker Health Interventions, King County, Washington State, 2012-2013. Prev Chronic Dis. 2016 06 02;13:E73. doi: 10.5888/pcd13.160013. PMID: 27253636. **Exclusion reason:** Ineligible study design


C-102


1424. Vega S. Nicotine replacement therapy in grocery stores; but wait, there's more. N Z Med J. 2011 Jun 10;124(1336):110-1. PMID: 21946758. **Exclusion reason:** Ineligible publication type


1429. Vesey JL. PVD screenings offer revenue opportunities. Health Care Strateg Manage. 2003 Apr;21(4):1, 17-9. PMID: 12747077. **Exclusion reason:** Ineligible publication type


1491. Watson BI. African American pastors' perspectives on health promotion ministries. Diss Abstr Int. 2018,78(10-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible intervention


1494. Watson Y. The cure for prevention is cultural sensitivity. Ethn Inequal Health Soc Care. 2008;1(2):8-10. **Exclusion reason:** Ineligible publication type


1530. Wellman G. Smoking makes me ugly. S D Med. 2010 Nov;63(11):371. PMID: 21117515. **Exclusion reason:** Ineligible publication type


1552. White AL. Racial/ethnic disparities in colorectal cancer screening and survival in a large nationwide population-based cohort. Diss Abstr Int. 2010;70(7-B):4061. Exclusion reason: Ineligible study design
1553. White J, Heney J, Esquibel AY, et al. Teaching and addressing health disparities through the family medicine social and community context of care project. R I Med. 2014 Sep 02;97(9):26-30. PMID: 25181743. **Exclusion reason:** Ineligible publication type


1565. Wilcox MR. Community Paramedicine in a Rural Setting. Minnesota's approach includes free clinics and a mobile unit that travels the community. EMS world. 2016 Feb;45(2):17-9. PMID: 26946585. **Exclusion reason:** Ineligible publication type


1574. Williams AJ. Racial/ethnic disparities in colorectal cancer screening among United States community-based residents. Diss Abstr Int. 2013;73(9-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible study design


1578. Williams F. Spatial cluster analysis of female breast cancer diagnosis in Missouri: Using gis and spatial analyst functions. Diss Abstr Int. 2014;75(3-B(E)):No Pagination Specified. **Exclusion reason:** Ineligible study design


1605. Wilson T. Breast cancer screening beliefs and barriers among college-aged women. Diss Abstr Int. 2016;76(11-B(E)) Pagination Specified. **Exclusion reason:** Ineligible study design


1614. Wojcik BE, Spinks MK, Stein CR. Effects of screening mammography on the comparative survival rates of African American, white, and Hispanic beneficiaries of a comprehensive health care system. Breast J. 2003 May-Jun;9(3):175-83. PMID: 12752625. **Exclusion reason:** Ineligible study design

1615. Wolf AB, Brem RF. Decreased mammography utilization in the United States: why and how can we reverse the trend? AJR Am J Roentgenol. 2009 Feb;192(2):400-2. doi: 10.2214/AJR.08.1873. PMID: 19155401. **Exclusion reason:** Ineligible publication type


1621. Wong CM. An evaluation of recruitment and retention strategies among Asian American women in the National Breast and Cervical Cancer Early Detection Program. Diss Abstr Int. 2007;68(4-B):2305. **Exclusion reason:** Ineligible study design


Wujcik DM. All nurses can address disparities in their communities. ONS Connect. 2008 Jun;23(6):7. PMID: 18572871. Exclusion reason: Ineligible publication type


1684. Yancy CW. Cardiovascular disease outcomes: priorities today, priorities tomorrow for research and community health. Ethn Dis. 2012;22(3 Suppl 1):S1-7-12. PMID: 23156833. **Exclusion reason:** Ineligible publication type


1694. Yeh W-S. Association between cancer and the detection and management of comorbid health conditions among elderly men with prostate cancer in the United States. Diss Abstr Int. 2011;71(8-B):4780. **Exclusion reason:** Ineligible population


1712. Zarchy T. Projected national impact of colorectal cancer screening on clinical and economic outcomes and health services demand. Gastroenterology. 2006 Mar;130(3):1012; author reply PMID: 16530546. **Exclusion reason:** Ineligible publication type


Appendix D. Study Design Algorithm

Figure D-1. Study design algorithm

See below

See above

Appendix E. Criteria for Assessing Quality and External Validity of Individual Studies

USPSTF Criteria for Assessing Quality

Randomized controlled Trials and Cohort Studies*

Criteria:

- Initial assembly of comparable groups:
- For randomized controlled trials (RCTs): Adequate randomization, including first concealment and whether potential confounders were distributed equally among groups
- For cohort studies: Consideration of potential confounders, with either restriction or measurement for adjustment in the analysis; consideration of inception cohorts
- Maintenance of comparable groups (includes attrition, cross-overs, adherence, contamination)
- Important differential loss to followup or overall high loss to followup
- Measurements: equal, reliable, and valid (includes masking of outcome assessment)
- Clear definition of interventions
- All important outcomes considered
- Analysis: adjustment for potential confounders for cohort studies or intention-to treat analysis for RCTs

Definition of ratings based on above criteria:

**Good:** Meets all criteria: Comparable groups are assembled initially and maintained throughout the study (followup ≥80%); reliable and valid measurement instruments are used and applied equally to all groups; interventions are spelled out clearly; all important outcomes are considered; and appropriate attention to confounders in analysis. In addition, intention-to-treat analysis is used for RCTs.

**Fair:** Studies are graded “fair” if any or all of the following problems occur, without the fatal flaws noted in the “poor” category below: Generally comparable groups are assembled initially, but some question remains whether some (although not major) differences occurred with followup; measurement instruments are acceptable (although not the best) and generally applied equally; some but not all important outcomes are considered; and some but not all potential confounders are accounted for. Intention-to-treat analysis is used for RCTs.

**Poor:** Studies are graded “poor” if any of the following fatal flaws exists: Groups assembled initially are not close to being comparable or maintained throughout the study; unreliable or invalid measurement instruments are used or not applied equally among groups (including not masking outcome assessment); and key confounders are given little or no attention. Intention-to-treat analysis is lacking for RCTs.
USPSTF Criteria for Assessing External Validity*

Each study that is identified as providing evidence to answer a key question is assessed according to its external validity (generalizability), using the following criteria.

**Study population:** The degree to which a study’s subjects constitute a special population—either because they were selected from a larger eligible population or because they do not represent persons who are likely to seek or be candidates for the preventive service. The selection has the potential to affect the following:

- **Absolute risk:** The background rate of outcomes in the study could be greater or less than what might be expected in asymptomatic persons because of the inclusion/exclusion criteria, nonparticipation, or other reasons.
- **Harms:** The harms observed in the study could be greater or less than what might be expected in asymptomatic persons.

The following are features of the study population and the study design that may cause a participant’s experience in the study to be different from what would be observed in the U.S. primary care population:

- **Demographic characteristics** (i.e., age, sex, ethnicity, education, income): The criteria for inclusion/exclusion or nonparticipation do not encompass the range of persons who are likely to be candidates for the preventive service in the U.S. primary care population.
- **Comorbid conditions:** The frequency of comorbid conditions in the study population does not represent the frequency likely to be encountered in persons who seek the preventive service in the U.S. primary care population.
- **Special inclusion/exclusion criteria:** There are other special inclusion/exclusion criteria that make the study population not representative of the U.S. primary care population.
- **Refusal rate** (i.e., ratio of included to not included but eligible participants): The refusal rate among eligible study subjects is high, making the study population not representative of the U.S. primary care population, even among eligible enrollees.
- **Adherence** (i.e., run-in phase, frequent contact to monitor adherence): The study design has features that may increase the effect of the intervention in the study more than would be expected in a clinically observed population.
- **Stage or severity of disease:** The selection of subjects for the study includes persons at a disease stage that is earlier or later than would be found in persons who are candidates for the preventive service.
- **Recruitment:** The sources for recruiting subjects for the study and/or the effort and intensity of recruitment may distort the characteristics of the study subjects in ways that could increase the effect of the intervention as it is observed in the study.

**Study setting:** The degree to which the clinical experience in the setting in which the study was conducted is likely to be reproduced in other settings:

- **Health care system:** The clinical experience in the system in which the study was conducted is not likely to be the same as that experienced in other systems (e.g., the system provides essential services for free when these services are only available at a high cost in other systems).
• Country: The clinical experience in the country in which the study was conducted is not likely to be the same as that in the United States (e.g., services available in the United States are not widely available in the other country or vice versa).
• Selection of participating centers: The clinical experience in which the study was conducted is not likely to be the same as in offices/hospitals/settings where the service is delivered to the U.S. primary care population (e.g., the center provides ancillary services that are not generally available).
• Time, effort, and system cost for the intervention: The time, effort, and cost to develop the service in the study is more than would be available outside the study setting.

Study providers: The degree to which the providers in the study have the skills and expertise likely to be available in general settings:
• Training to implement the intervention: Providers in the study are given special training not likely to be available or required in U.S. primary care settings.
• Expertise or skill to implement the intervention: Providers in the study have expertise and/or skills at a higher level than would likely be encountered in typical settings.
• Ancillary providers: The study intervention relies on ancillary providers who are not likely to be available in typical settings.

Global Rating of External Validity (Generalizability; Applicability)

External validity is rated “good” if:
• The study differs minimally from the U.S. primary care population/setting/providers and only in ways that are unlikely to affect the outcome; it is highly probable (>90%) that the clinical experience with the intervention observed in the study will be attained in the U.S. primary care setting.

External validity is rated “fair” if:
• The study differs from the U.S. primary care population/setting/providers in a few ways that have the potential to affect the outcome in a clinically important way; it is moderately probable (50% to 89%) that the clinical experience with the intervention observed in the study will be attained in the U.S. primary care setting.

External validity is rated “poor” if:
• The study differs from the U.S. primary care population/setting/providers in many ways that have a high likelihood of affecting the clinical outcome; probability is low (<50%) that the clinical experience with the intervention observed in the study will be attained in the U.S. primary care setting.

Systematic Reviews

Criteria:
• A priori design provided
• Dual study selection and data extraction
• Comprehensiveness of sources considered/search strategy used
• Searched for more than published literature
• List of included and excluded studies provided
• Characteristics of included studies provided
• Standard appraisal of included studies
• Validity of conclusions
• Likelihood of publication bias assessed
• Conflict of interest stated

Definition of ratings based on above criteria:
Good: Recent, relevant review with comprehensive sources and search strategies; explicit and relevant selection criteria; standard appraisal of included studies; and valid conclusions
Fair: Recent, relevant review that is not clearly biased but lacks comprehensive sources and search strategies
Poor: Outdated, irrelevant, or biased review without systematic search for studies, explicit selection criteria, or standard appraisal of studies

### Appendix F. Evidence Tables

Table F-1. Effects of impediments and barriers on the part of populations adversely affected by disparities that contribute to disparities in preventive services: study characteristics

<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Preventive Service</th>
<th>Disparity Population</th>
<th>Study Design (N)</th>
<th>Population; Age (mean; range); Gender; Race</th>
<th>Setting</th>
<th>Intervention (n) / Analyses</th>
<th>Comparison (n)</th>
<th>Duration; Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ahluwalia et al., 2002</td>
<td>Tobacco Smoking Cessation in Adults: Behavioral and Pharmacotherapy Interventions</td>
<td>African Americans</td>
<td>Secondary data analysis of a physician counseling intervention study for smoking cessation to examine the effect of having a regular source of healthcare on smoking behaviors (879)</td>
<td>Intervention vs. Control Mean age (SD): 44.1 ±13.2 vs. 43.2 ±12.5 Male: 47% vs. 53% Race/ethnicity: African American: 100%</td>
<td>Large inner-city hospital; geographic location not reported</td>
<td>Secondary data analysis of a physician counseling intervention study for smoking cessation to examine the effect of having a regular source of healthcare on smoking behaviors</td>
<td>Having regular source of healthcare (202) vs. not having usual source of care (677)</td>
<td>Cross sectional analysis at posttest time point</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
<td>Setting</td>
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<tr>
<td>Bacio et al., 2014</td>
<td>Tobacco smoking cessation in adults: Behavioral and pharmacotherapy interventions</td>
<td>African American</td>
<td>Secondary data analysis of baseline data for an RCT before participants were randomized to smoking cessation medication. Eligible participants were non-treatment seeking daily smokers (smoked ≥10 cigarettes per day) who were also heavy drinkers (≥14 drinks/week for men; ≥7 for women). (314)</td>
<td>Mean age: 36.29 (SD 10.7) Female: 31% Race/ethnicity: African American: 155 White: 159</td>
<td>Community sample; geographic location not reported</td>
<td>Mediation OLS and logistic regression analyses to identify potential smoking motive (WISDM scale) mediators in racial and ethnic differences in smoking patterns</td>
<td>Mediation analyses testing whether smoking motives as measured by WISDM subscales explain higher rates of failed quit attempts reported by Black (155) compared to White (159) regular smokers.</td>
<td>Mediation analysis of larger RCT</td>
</tr>
<tr>
<td>Clark et al., 2009</td>
<td>Breast cancer screening</td>
<td>African American women</td>
<td>Before-after study (437)</td>
<td>Mean age: 51 (SD 8.5) Female: 100% African American: 100%</td>
<td>Community health centers and primary care clinics; Boston MA</td>
<td>Multipronged case management intervention provided tailored services designed to address barriers to screening</td>
<td>Women as own comparators over time: changes in screening uptake after the intervention (437)</td>
<td>5 years (January 2002-February 2007)</td>
</tr>
<tr>
<td>Clark et al., 2011</td>
<td>Cervical cancer screening</td>
<td>African American women</td>
<td>Before-after study (732)</td>
<td>Mean age NR Age 18 to 49: 78% Age ≥50: 22% Female: 100% African American: 100%</td>
<td>Community health centers and primary care clinics; Boston MA</td>
<td>Multipronged case management intervention provided tailored services designed to address barriers to screening</td>
<td>Women as own comparators over time: changes in screening uptake after the intervention (732)</td>
<td>5 years (January 2002-February 2007)</td>
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<tr>
<td>Author, Year (See Appendix B for full citation)</td>
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<tr>
<td>Fang et al., 2017</td>
<td>Cervical cancer screening</td>
<td>Korean American women</td>
<td>2-arm group randomized RCT. Mixed-methods logistic regression analyses at 12-months after the program to examine patient-level effects for factors that were not balanced in the randomization. (705)</td>
<td>Mean age±SD control: 53.9±11.6 intervention: 51.9±9.5 Female: 100% Korean American: 100%</td>
<td>Churches (community setting); Southeastern PA and NJ</td>
<td>Multicomponent program that includes navigation services and bilingual community health educators to address individual beliefs and expectations on cervical cancer screening including perceived risks, perceived benefits, perceived barriers, and cultural norms. (347)</td>
<td>Information-only control group: bilingual community health educators deliver general information on health, cancer education, screening guidelines (358)</td>
<td>Duration: February 2009 to December 2014 Followup: 12 months</td>
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<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
<td>Setting</td>
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<tr>
<td>Guillaume et al., 2017a</td>
<td>Breast cancer screening</td>
<td>Rural and/or Low-Income Women</td>
<td>Longitudinal cohort study (64,102)</td>
<td>Mean age NR ≤54: 42.22% 55 to 59: 17.52% 60 to 64: 13.21% 65 to 69: 13.51% 70+: 13.54% Female: 100%</td>
<td>Orne, France</td>
<td>Assess the efficacy of mobile mammography in reducing social and geographic inequalities in breast cancer screening using multilevel mixed logistic models with random effects. Estimated the following: the screening participation rate according to deprivation and remoteness in both groups and in the total population; differences observed in the only RO group (reflecting screening without MM); and those observed in the total population (reflecting access to MM among specific populations).</td>
<td>Two groups: women invited to screening through their radiologist office (RO group) (35,804) and women invited to screening though their radiologist office or the mobile mammography van (MM or RO group) (28,298)</td>
<td>September 2003 to December 2012</td>
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<td>Author, Year (See Appendix B for full citation)</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
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<tr>
<td>Hendren et al., 2014</td>
<td>Colorectal and breast cancer screening</td>
<td>Low-income</td>
<td>RCT (366) CRC screening: 240 Mammography: 191</td>
<td>Control vs. Intervention CRC Screening</td>
<td>Large safety net primary care practice; Rochester NY</td>
<td>Using EHR record review patients past due for CRC screening and/or mammography were randomized to a multi-modal intervention including: 1) letters; 2) automated telephone calls; 3) point-of-care prompts reminding clinicians and patients the patient was past due for the service; 4) mailing of home test kit for CRC screening patients (185) Type of CRC screening: colonoscopy, FIT, FOBT</td>
<td>Control group (181)</td>
<td>Duration: 6 months Followup: 1 year</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
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<tr>
<td>Jandorf et al., 2014</td>
<td>Breast and cervical cancer screening</td>
<td>Latinas</td>
<td>Cluster randomized study (1,333)</td>
<td>Mean age NR Female: 100% Latina: 100%</td>
<td>Community based settings in Arkansas, Buffalo, and NYC</td>
<td>Multivariate generalized linear-mixed model controlling for demographic, geographic, barriers to screening (yes/no), and navigation characteristics (e.g., number of calls).</td>
<td>Faith-based intervention using peer/lay health workers (LHA, promotoras) (803)</td>
<td>Diabetes prevention education group vs. breast and cervical cancer education group (530)</td>
</tr>
<tr>
<td>Lee-Lin et al., 2015</td>
<td>Breast cancer screening</td>
<td>Low-income Chinese-American immigrant women</td>
<td>RCT (300)</td>
<td>Mean age: 58.8 (range 40 to 85) Female: 100% Chinese immigrant: 100%</td>
<td>Chinese communities in Portland, OR</td>
<td>The two-part culturally-targeted educational intervention consisted of group teaching with targeted, theory-based messages followed by individual counseling sessions (147)</td>
<td>Control received a mammography screening brochure published by the National Cancer Institute (153)</td>
<td>Duration: April 2010 to September 2011 Followup: 3, 6, 12 months</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
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<tr>
<td>Roetzheim et al., 2004</td>
<td>Breast, cervical, colorectal cancer screening</td>
<td>Insurance status</td>
<td>Cluster RCT (1,196) 8 Practices</td>
<td>Age 50 to 56: 37.1% 57 to 63: 33% 64 to 75: 29.8% Female: 78.2% Race AA/Black: 29.1% White: 48.4% Hispanic: 22.5%</td>
<td>8 clinics; Hillsborough County FL</td>
<td>Cancer screening checklist completed by patients, stickers to designate whether screening was ordered/completed. (600) Type of CRC screening: FOBT</td>
<td>Usual care (596)</td>
<td>12 months and 24 months</td>
</tr>
<tr>
<td>Smith et al., 2017 (Blumenthal et al., 2010)</td>
<td>Colorectal cancer screening</td>
<td>African American</td>
<td>Secondary analysis of participants who did not receive screening in a RCT (257)</td>
<td>Mean age: NR Gender: NR Race/ethnicity: African-American: 100%</td>
<td>Community (no details provided in this publication) Randomized to one of the following: A1) Reduced out of pocket cohort: members reimbursed for personal expenses incurred in screening (63) A2) One-on-one education cohort: members met with health educator in 3 weekly sessions (67) A3) Group education cohort: members met with health educator in four weekly sessions (65) Type of CRC Screening: any type of CRC screening</td>
<td>B) Control cohort: members received no intervention (62)</td>
<td>Duration: 6 months Followup at 3 and 6 months; losses not reported</td>
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<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
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<tr>
<td>Studts et al., 2012</td>
<td>Cervical cancer screening</td>
<td>Rural, low income</td>
<td>Single-blind (data collectors and investigators) RCT (345)</td>
<td>Age: mean not reported; 40% &lt;50 years Female: 100% Race/ethnicity: White: 95.1% Black: 4.6% American Indian: 0.3%</td>
<td>Recruitment: Churches initially then replaced with snowball sampling in which staff personally contacted church representatives Intervention: In-home Geographic region: Appalachian KY: Harlan, Knott, Letcher, and Perry counties</td>
<td>Trained lay health advisors (LHA) similar in characteristics to participants delivered tailored home visits and newsletters that addressed participant-identified barriers from baseline assessment (176) All participants attended an educational lunch program that delivered information on cervical cancer screening and prevention</td>
<td>Wait list (deferred) until post followup at 8 months; between 8-month followup and end of study all participants received intervention (169)</td>
<td>Duration: 14 months Followup: 4, 8, 14 months; 96% followup overall (95% in treatment, 97% in intervention)</td>
</tr>
<tr>
<td>White et al., 2012</td>
<td>Cervical and breast cancer screening</td>
<td>Latina immigrants</td>
<td>Before-after study (782) Pap smear: 782 Mammogram: 229</td>
<td>Age Median: 33 years 19-39 years: 70.7% 40-49 years: 19.4% 50-88 years: 9.9%</td>
<td>Public hospital, private non-profit hospital, local health department, community health clinic. Birmingham AL</td>
<td>Low-cost pap smears, no-cost mammograms offered to attendees at educational luncheons</td>
<td>Pre-post (782)</td>
<td>Six years (2003-2009)</td>
</tr>
</tbody>
</table>

**Abbreviations:** CBE = clinical breast exam; CRC = colorectal cancer; EHR = electronic health record; FIT = fecal immunochemical test; FOBT = fecal occult blood test; LHA = lay health advisors; MM = mobile mammography; NR = not reported; OLS = ordinary least squares; Pap = Papanicolaou test; RCT = randomized controlled trial; RO = radiologist office; SD = standard deviation; WISDM = Wisconsin Inventory of Smoking Dependence Motives

**See Appendix B. Included Studies for full citations**
Table F-2. Effects of impediments and barriers on the part of populations adversely affected by disparities that contribute to disparities in preventive services: outcomes

<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
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</thead>
<tbody>
<tr>
<td>Ahluwalia et al., 2002</td>
<td>Multivariate analysis of the effect of regular source of healthcare on smoking related behavior adjusted for history of diabetes, hypertension, age group, gender, and experimental group, AOR (95% CI): Quit attempts in the past year: 0.98 (0.69 to 1.41), p=0.94 Intent to quit in the next 6 months: 0.90 (0.61 to 1.32), p=0.59 Intent to quit in the next 30 days: 1.46 (1.04 to 2.05), p=0.03 Ever receiving physician advice to quit: 1.46 (1.02 to 2.10), p=0.04 Light smoking (≤ 10 cig/day): 1.42 (1.00 to 2.03), p=0.05</td>
<td>NA</td>
<td>Fair 1. Exclusive population of African-American smokers in one geographically confined community setting</td>
</tr>
<tr>
<td>Bacio et al., 2014</td>
<td>Race had a significant indirect effect on failed quit attempts through following motives: Negative reinforcement (Indirect effect b=0.05, SE 0.02; 95% CI [0.02 to 0.11]) Positive reinforcement (Indirect effect b=0.05, SE 0.02; 95% CI [0.17 to 0.12]) Taste/sensory processes (Indirect effect b=0.06, SE 0.3; 95% CI [0.02 to 0.12]) Behavioral choice and craving were not significant mediators of the relationship between race and failed quit attempts. Specifically, Black, compared to White, daily smokers were less motivated to smoke to experience the positive reinforcement, negative reinforcement, and taste/sensory processes related to smoking. However, endorsing lower motivation to smoke did not appear to be sufficient to help Black daily smokers successfully quit smoking. Results suggest that smoking cessation interventions may help reduce tobacco-related health disparities by recognizing that lower endorsement of some smoking motives are less consistently linked to quit attempts in Black, compared to White, smokers.</td>
<td>NA</td>
<td>Fair 1. Exclusive population consisting of a community sample of non-treatment seeking daily smokers who drank heavily and responded to an ad.</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Outcomes</td>
<td>Quality Rating</td>
<td>Applicability Rating</td>
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<tr>
<td>Clark et al., 2009</td>
<td>Patient related predictors of mammography uptake among women age 40+ for women who had at least one mammogram, AOR (95% CI)</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td>Women ≥ 40 (n=437)</td>
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<td>1. Used request for proposal process to identify intervention sites (large community health centers servicing large numbers of women of African descent).</td>
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<td>No regular provider: 0.20 (0.07 to 0.62), p&lt;0.05</td>
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<td>Housing concerns at baseline: 0.40 (0.21 to 0.77), p&lt;0.05</td>
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<td></td>
<td>Having public insurance (Medicare/Medicaid): 0.98 (0.45 to 2.12), NS</td>
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<td>Uninsured relative to being privately insured: 2.08 (0.73 to 5.91),  NS</td>
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<td>Women ≥ 50 (n=223)</td>
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<td>Housing concerns at baseline: 0.65 (0.21 to 2.03), NS</td>
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<td></td>
<td>Having public insurance (Medicare/Medicaid): 1.34 (0.39 to 4.61), NS</td>
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<td>Uninsured relative to being privately insured: 2.25 (0.47 to 10.77), NS</td>
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<tr>
<td></td>
<td>Patient related predictors of repeated (longitudinal) mammography screening among women AOR (95% CI)</td>
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<td>Women ≥ 40 (n=390)</td>
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<td></td>
<td>Public insurance: 0.72 (0.50 to 1.05), NS</td>
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<td>Housing concerns at baseline: 0.85 (0.61 to 1.18), NS</td>
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<td></td>
<td>Uninsured: 0.54 (0.35 to 0.85), p&lt;0.05</td>
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<td>Family history of breast cancer: 0.64 (0.44 to 0.94), p&lt;0.05</td>
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<td>Recent mammogram at baseline: 2.16 (1.51 to 3.09), p&lt;0.05</td>
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<td>Non-U.S. born: 1.68 (1.15 to 2.47), p&lt;0.05</td>
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<tr>
<td></td>
<td>Women ≥ 50 (n=196)</td>
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<tr>
<td></td>
<td>Public insurance: 0.85 (0.47 to 1.54), NS</td>
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<td>Housing concerns at baseline: 0.86 (0.51 to 1.45), NS</td>
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<td>Uninsured: 0.42 (0.20 to 0.87), p&lt;0.05</td>
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<tr>
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<td>Family history of breast cancer: 0.74 (0.42 to 1.32), NS</td>
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<tr>
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<td>Recent mammogram at baseline: 1.94 (1.07 to 3.52), p&lt;0.05</td>
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<td></td>
<td>Non-U.S. born: 2.41 (1.29 to 4.49), p&lt;0.05</td>
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<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Outcomes</td>
<td>Quality Rating</td>
<td>Applicability Rating</td>
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</tr>
<tr>
<td>Clark et al., 2011</td>
<td>Barriers defined by the study included social and healthcare system barriers: insurance coverage, lacking a regular provider, concerns communicating with provider, poor self-rated health, educational attainment, housing concerns, and social support for childcare.</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td>Barriers to receiving Pap smear screening, AOR (95% CI)</td>
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<tr>
<td></td>
<td>Lacking a regular clinical provider: 0.20 (0.11 to 0.37)</td>
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<td></td>
<td>Concerns communicating with clinical providers: 0.45 (0.27 to 0.74)</td>
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<td></td>
<td>Poor self-rated health: 0.71 (0.52 to 0.96)</td>
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<td></td>
<td>Low educational attainment-less than high school: 0.54 (0.30 to 0.99)</td>
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<td>Low educational attainment-high school/GED: 0.50 (0.28 to 0.88)</td>
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<tr>
<td></td>
<td>Impact of case management on obtaining repeated, longitudinal Pap smear screenings at recommended intervals, AOR (95% CI)</td>
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<td></td>
<td>Having social support for childcare:</td>
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<td></td>
<td>All participants due for screening: 1.94 (1.28 to 2.93), p&lt;0.05</td>
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<td></td>
<td>Did not have a Pap smear at baseline: 3.52 (1.28 to 9.69), p&lt;0.05</td>
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<td>Did have a Pap smear at baseline: 1.57 (0.98 to 2.5), p&lt;0.06</td>
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<td></td>
<td>Insurance status- Public insurance (Medicare/Medicaid)</td>
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<td>All participants due for screening: 0.65 (0.38 to 1.09)</td>
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<tr>
<td></td>
<td>Did not have a Pap smear at baseline: 1.11 (0.32 to 3.85)</td>
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<tr>
<td></td>
<td>Did have a Pap smear at baseline: 0.51 (0.27 to 0.97), p&lt;0.05</td>
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<tr>
<td></td>
<td>No other barriers were statistically significant in models.</td>
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<tr>
<td>Author, Year</td>
<td>Outcomes</td>
<td>Quality Rating</td>
<td>Applicability Rating</td>
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</table>
| Fang et al., 2017 | Barriers identified in paper: language and access barriers, lack of insurance, lack of familiarity with the U.S. healthcare system  
Receipt of cervical cancer screening:  
Intervention: OR 25.9; 95% CI (10.1 to 66.1), p<0.001  
Receipt of cervical cancer screening, covariate adjusted model (age, marital status, prior pap receipt, insurance coverage, usual source of care):  
Intervention: AOR 35.8; 95% CI (11.1 to 114.9), p<0.001  
Being insured: AOR 0.440; 95% CI (0.22 to 0.90); p=0.03  
Having a regular physician: AOR 0.93; 95% CI (0.46 to 1.86); p=0.85  
Authors note that fewer intervention group participants were insured or had a usual source of care compared to controls.  
Unscreened women were asked to descriptively provide reasons for not obtaining screening  
Intervention group (81 women):  
Perception that they were healthy or had no health problems (72 women, 80.9%), no time or being too busy (42 women; 47.2%), lack of insurance (18 women; 20.2%), physician did not mention screening (1 woman), no transportation (1 woman), and forgetting (1 woman).  
Control (268 women):  
Healthy or had no problems (97; 36.2%), lack of insurance (70; 26.1%), not knowing where to go or how to obtain screening (20 women; 7.4%), lack of time (18 women; 6.7%), did not like the Pap test (3 women), forgetting to obtain screening (1 woman), being too shy to undergo screening (2 women), and not having a physician (1 woman). | Fair 1. Differences in groups at baseline | Fair 1. Exclusive population consisting of only Korean American women |
| Guillaume et al., 2017a | RO group  
Individual participation was associated with deprivation quintile  
Lowest in deprived areas: Q4, AOR 0.83 (95% CI 0.71 to 0.96); Q5, AOR 0.81 (95% CI 0.69 to 0.95)  
Individual participation was associated with distance to an RO:  
Participation decreasing with remoteness: 5 to 10km, AOR 0.91 (95% CI 0.81 to 1.01); 10 to 15km, AOR 0.75 (95% CI 0.66 to 0.85); 15 to 20km, AOR 0.61 (95% CI 0.53 to 0.70); 20 to 25km, AOR 0.47 (95% CI 0.40 to 0.56); 25 to 30km, AOR 0.47 (95% CI 0.39 to 0.57); >30km, AOR 0.54 (95% CI 0.42 to 0.69)  
MM or RO group  
Participation was not significantly associated with deprivation quintile or distance to an RO.  
Total population  
Influence of deprivation quintile and remoteness on participation was markedly lower than in the RO population.  
Influence of deprivation was significant only for the extreme most deprived quintile (Q5, AOR 0.85 [95% CI 0.75 to 0.97]). After adjustment, MM invitation was associated with statistically significant increase in individual participation (AOR 2.9; 95% CI 2.7 to 3.03). | Fair 1. Groups were not similar at baseline. 2. Unclear allocation concealment. | Fair 1. Geographic-level study of one regional area in France |
<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
</tr>
</thead>
</table>
| Hendren et al., 2014                          | Mammography Insurance: OR (95% CI)  
Private: 1.50 (0.36 to 6.19)  
Medicare: 6.24 (1.23 to 31.61), p<0.05  
Medicaid: 2.57 (0.57 to 11.59)  
None: reference (1.00)  
Household income: OR (95% CI)  
>$40,000: 2.65 (0.84 to 8.43)  
$30,000 to $39,000: 1.44 (0.49 to 4.29)  
<$30,000: reference (1.00)  
CRC screening Insurance: OR (95% CI)  
Private: 1.58 (0.38 to 6.53)  
Medicare: 3.61 (0.83 to 15.55)  
Medicaid: 2.53 (0.57 to 11.21)  
None: reference (1.00)  
Household income: OR (95% CI)  
>$40,000: 1.88 (0.69 to 5.09)  
$30,000 to $39,000: 1.98 (0.83 to 4.76)  
<$30,000: reference (1.00) | Fair  
1. Care providers not masked, unclear if patients masked, attrition and loss to followup not reported | Good |
<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
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</thead>
<tbody>
<tr>
<td>Jandorf et al., 2014</td>
<td>Barriers: lack of money and lack of time, although other demographic factors were considered. Only significant associations were reported in the paper, therefore it was not possible to report results of non-significant findings for the barriers of interest. Mammography adherence Baseline to 2-month assessment: OR 2.16; 95% CI 1.69 to 2.76 Baseline to 8 months: OR 8.56; 95% CI 5.85 to 12.53 2 months vs. 8 months: OR 3.97; 95% CI 2.70 to 5.82 Residing in NYC vs, WNY: OR 0.55; 95% CI 0.37 to 0.80 No significant differences between living in AR and NYC or AR vs. WNY Puerto Rican ethnicity were marginally more likely to be adherent than those born in countries outside the USA or Puerto Rico. Having health insurance: OR 2.48 95% CI 1.67 to 3.70 Pap adherent at baseline: OR 5.85; 95% 4.24 to 8.06 Pap adherence Baseline to 2-month assessment: OR 2.14; 95% CI 1.87 to 2.45 Baseline to 8 months: OR 2.35; 95% CI 2.00 to 2.76 2 months vs. 8 months: OR 1.78; 95% CI 1.52 to 2 Participants of Puerto Rican ethnicity vs. born elsewhere, adherent at 2 and 8 months: OR 1.35; 95% CI 1.09 to 1.67 Significant time by program type interaction (Wald chi-square=6.10; p=0.0472). Baseline: no significant difference in adherence between groups 2-month assessment- women in cancer group were less likely to be adherent: OR 0.74; 95% CI 0.59 to 0.94 8-month assessment- no adherence differences</td>
<td>Fair 1. Allocation concealment not reported. 2. Unclear whether groups were similar at baseline.</td>
<td>Fair 1. Exclusive population consisting of only Latinas</td>
</tr>
<tr>
<td>Lee-Lin et al., 2015</td>
<td>Barriers: older age, lower education and income, poor cancer knowledge, lack of time, absence of symptoms, lower perceived susceptibility to breast cancer, and limited ability to communicate in English Controlled for: marital status, age of participant, and age at migration to US When variables were controlled together, women in the intervention group were nine times more likely to complete a mammogram at 6 months postintervention, the highest point of the intervention effect 3-month: AOR 8.81, 95% CI 4.83 to 16.05, p&lt;0.001 6-month: AOR 9.10, 95% CI 3.50 to 23.62, p&lt;0.001 12-month AOR 4.61, 95% CI 1.59 to 13.37, p&lt;0.001 None of the included covariates were significant in the multivariable model. Overall, education, employment, income, English proficiency, having a regular healthcare provider, reporting healthcare provider recommendation, and having mammography insurance coverage were not significant predictors in this study.</td>
<td>Fair 1. Poor reporting re: allocation concealment, randomization 2. Unclear whether ITT was used or post randomization exclusions to synthesis.</td>
<td>Fair 1. Exclusive population consisting of only Chinese American immigrant women</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Outcomes</td>
<td>Quality Rating</td>
<td>Applicability Rating</td>
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</tbody>
</table>
| Roetzheim et al., 2004 | Mammography  
Health insurance: OR (95% CI), p value  
County: reference (1.00)  
Medicare: 0.77 (0.57 to 1.06), 0.11  
Medicaid: 0.89 (0.64 to 1.26), 0.52  
Other: 0.86 (0.57 to 1.31), 0.48  

Pap smear  
Health insurance: OR (95% CI), p value  
County: reference (1.00)  
Medicare: 0.63 (0.43 to 0.92), 0.02  
Medicaid: 0.73 (0.48 to 1.09), 0.12  
Other: 1.04 (0.63 to 1.72), 0.89  

CRC/FOBT  
Health insurance: OR (95% CI), p value  
County: reference (1.00)  
Medicare: 0.73 (0.54 to 0.998), 0.047  
Medicaid: 0.83 (0.60 to 1.16), 0.28  
Other: 0.82 (0.54 to 1.23), 0.34 | Fair  
1. No info re; randomization/allocation | Fair  
1. Population - NY vs. other states |

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
</tr>
</thead>
</table>
| Mammography  
Health insurance: OR (95% CI), p value  
County: reference (1.00)  
Medicare: 0.77 (0.57 to 1.06), 0.11  
Medicaid: 0.89 (0.64 to 1.26), 0.52  
Other: 0.86 (0.57 to 1.31), 0.48  

Pap smear  
Health insurance: OR (95% CI), p value  
County: reference (1.00)  
Medicare: 0.63 (0.43 to 0.92), 0.02  
Medicaid: 0.73 (0.48 to 1.09), 0.12  
Other: 1.04 (0.63 to 1.72), 0.89  

CRC/FOBT  
Health insurance: OR (95% CI), p value  
County: reference (1.00)  
Medicare: 0.73 (0.54 to 0.998), 0.047  
Medicaid: 0.83 (0.60 to 1.16), 0.28  
Other: 0.82 (0.54 to 1.23), 0.34 | Fair  
1. No info re; randomization/allocation | Fair  
1. Population - NY vs. other states |
<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
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</thead>
<tbody>
<tr>
<td>Smith et al., 2017 (Blumenthal et al., 2010)</td>
<td>Overall 64/257 (24.7%) screened A1: 14/63 (22.2%) A2: 17/67 (25.4%) A3: 22/65 (33.9%) B: 11/62 (17.7%) A3 vs. B, p=0.039; all other interventions did not significantly change screening vs. control Post-intervention among those in group A3, psychological and attitudinal testing for those who sought screening were compared with those who did not screen; mean scores on the Attitudes, Benefits, and Barriers Assessment approached significance (screened: mean score 19.0, SD 3.5 vs. not screened: mean score 16.0, SD 4.8; p=0.0816); in logistic regression model, this scale demonstrated statistical significance (p=0.0276); fatalism, perceived stress, and self-esteem scores were not associated with screening; social support and social network diversity were greater among those who screened vs. not screened, but this difference was not statistically significant Group: OR 1.168, 95% CI 0.837 to 1.611, p=0.3437 Fatalism Scale: OR 1.168, 95% CI 0.965 to 1.396, p=0.1883 Attitudes, Barriers, and Beliefs Scale: OR 1.121, 95% CI 1.013 to 1.242, p=0.0276 Rosenberg Self-esteem Scale: OR 1.002, 95% CI 0.925 to 1.087, p=0.9523 Social Support Scale: OR 1.004, 95% CI 0.814 to 1.249, p=0.9364 Social Network Diversity Scale: OR 1.009, 95% CI 0.814 to 1.249, p=0.9364 Note: Attitudes, Benefits, Barriers Assessment was constructed by research team to get perspective of participants on cancer screening. References 2-3 may have more information on how the scale is coded.</td>
<td>NA</td>
<td>Fair 1. Exclusive population consisting of only African American immigrant women</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Outcomes</td>
<td>Quality Rating</td>
<td>Applicability Rating</td>
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<tr>
<td>Studts et al., 2012</td>
<td>Intervention vs. Control Pap at 4-month followup, n (%): 12 (6.8%) vs. 11 (6.5%) Pap at 8-month followup (primary outcome): 31 (18%) vs. 19 (11%); AOR1 2.56, 95% CI 1.03 to 6.38, p=0.04; AOR2 2.73, 95% CI 1.08 to 6.89, p=0.03 AOR1: adjusted for effect of church AOR2: adjusted for church and participant characteristics (age, marital status, perceived health status, baseline screening status) Excluding 23 participants who obtained Pap test between 4- and 8-months: 19 (11.6%) vs. 8 (5.1%); OR 2.59, 95% CI 1.04 to 6.46, p=0.04 Pap at 14-month followup (including only women who were still need of a Pap: 20/145 (13.8%) vs. 40/158 (25.3%) Among controls, women obtaining Pap between baseline and 8-month followup vs. post-8-month followup and end of study increased from 8 (5.1%) to 40 (25.3%); McNemar's X2 21.3 (1 df, n=158), p&lt;0.001 Factors associated with getting Pap Women age 55 to 59 years were less likely than those age 40-44 years to get a Pap; OR 0.41, 95% CI 0.20 to 0.86, p&lt;0.05 Women who had Pap smear &gt;1 year and &lt;5 years ago were more likely than those with Pap &gt;5 years ago to get a Pap; OR 2.50, 95% CI 1.47 to 4.25, p&lt;0.001 No other factors were statistically significant including race, marital status, education, employment status, annual household income, perceived financial status, health insurance, perceived health status (all adjusted for treatment group and church)</td>
<td>Good</td>
<td>Fair 1. Limited to rural Appalachian women in Kentucky</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Outcomes</td>
<td>Quality Rating</td>
<td>Applicability Rating</td>
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<tr>
<td>White et al., 2012</td>
<td>Scheduled Pap smear: 80% Of those scheduling Pap (N=626), attended appointment: 65%</td>
<td>NA</td>
<td>Poor</td>
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<tr>
<td></td>
<td>Multivariable-adjusted prevalence ratio (aPR), % (95% CI), p value</td>
<td></td>
<td>1. Study population (demographics, inclusion / exclusion criteria)</td>
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<tr>
<td></td>
<td>Scheduled a Pap Smear: Prior screening &lt;1 year: 70%, 1.00 Prior screening in past 1 to 3 years: 87.5%, 1.18 (1.09 to 1.28), p&lt;0.001 Prior screening ≥ 3 years ago or does not remember: 1.16 (1.05 to 1.28), p&lt;0.01 No prior screening: 1.01 (0.88 to 1.17) Does not know where to get screening: 87.7%, 1.00 Does know where to get screening: 73.6%, 0.90 (0.83 to 0.96), p&lt;0.01 Has not lived in Alabama ≥5 years: 82.9%, 1.00 Has lived in Alabama ≥5 years: 75.4%, 0.96 (0.89 to 1.03) Does not have health insurance: 82.2%, 1.00 Does have health insurance: 50.9%, 0.64 (0.50 to 0.84), p&lt;0.01</td>
<td></td>
<td>2. Study setting (healthcare system, time, effort)</td>
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<tr>
<td></td>
<td>Scheduled mammogram (analytic sample only includes women ≥40 years; n=229): 77.7% Of those scheduling mammogram (N=178), attended appointment: 79.2%</td>
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<td>3. Study providers (training, ancillary providers)</td>
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<td></td>
<td>Multivariable-adjusted prevalence ratio, % (95% CI), p value</td>
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<td>Scheduled a mammogram: Prior screening &lt;1 year: 41%, 1.00 Prior screening in past 1 to 3 years: 88%, 2.09 (1.46 to 3.00), p&lt;0.001 Prior screening ≥3 years ago or does not remember: 76%, 1.77 (1.17 to 2.67), p&lt;0.01 No prior screening: 85.6%, 1.90 (1.31 to 2.76), p&lt;0.01 Does not know where to get screening: 81.4%, 1.00 Knows where to get screening: 69.1%, 1.07 (0.92 to 1.24) Has not lived in Alabama ≥ 5 years: 25.5%, 1.00 Has lived in Alabama ≥ 5 years: 81.7%, 1.09 (0.96 to 1.24) Does not have health insurance: 81.8%, 1.00 Has health insurance: 35%, 0.45 (0.26 to 0.78), p&lt;0.01</td>
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</table>

**Abbreviations:** AOR = adjusted odds ratio; aPR = adjusted prevalence ratio; CI = confidence interval; CRC = colorectal cancer; df = degrees of freedom; FOBT = fecal occult blood test; GED = general education development; km = kilometers; MM = mobile mammography; NA = not applicable; NR = not reported; NS = not significant; OR = odds ratio; Pap = Papanicolaou test; RO = radiologist office; SD = standard deviation; SE = standard error; US = United States; WNY = west New York

*See Appendix B. Included Studies for full citations*
Table F-3. Effectiveness of strategies between providers and patients to reduce disparities in preventive services: study characteristics

<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Preventive Service</th>
<th>Disparity Population</th>
<th>Study Design (N)</th>
<th>Population; Age; Gender; Race</th>
<th>Setting</th>
<th>Interventions (n)</th>
<th>Comparison (n)</th>
<th>Duration; Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ahmed et al., 2010</td>
<td>Breast cancer screening</td>
<td>Low-income women</td>
<td>RCT (2,357)</td>
<td>Very low-income insured women</td>
<td>Tennessee Coordinated Care Network</td>
<td>A1. Simple intervention: reminder letters from managed care organization medical director (785)</td>
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<td>Mean age, in years (SD)</td>
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<td>Control: 52.8 (9.8)</td>
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<td>Intervention, simple: 52.9 (9.9)</td>
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<td>Intervention, stepwise: 52.8 (9.8)</td>
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<td>Race/ethnicity, % (n)</td>
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<td>White Control: 32.8 (349)</td>
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<td></td>
<td>Intervention, simple: 33.7 (358)</td>
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<td>Intervention, stepwise: 33.5 (356)</td>
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<td>Black Control: 33.7 (340)</td>
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<td>Intervention, simple: 32.8 (331)</td>
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<td></td>
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<td>Intervention, stepwise: 33.4 (337)</td>
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<td>Hispanic Control: 33.3 (97)</td>
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<td>Intervention, simple: 33.4 (96)</td>
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<td>Intervention, stepwise: 32.8 (94)</td>
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<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age; Gender; Race</td>
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<td>Interventions (n)</td>
<td>Comparison (n)</td>
<td>Duration; Followup</td>
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<tr>
<td>Bastani et al., 2015</td>
<td>Colorectal Cancer Screening</td>
<td>Unscreened first-degree relatives of people with colorectal cancer; Latino, African American, Asian, white</td>
<td>RCT (1,280)</td>
<td>Mean age: 51 years Gender: 56% female Race/ethnicity: 35% Latino, 27% Asian, 25% White, 19% African American</td>
<td>California Cancer Registry/ Community</td>
<td>A. Culturally-tailored printed educational materials sent 2 weeks after baseline, as well as barriers counseling via telephone at 6 months in those still unscreened (670)</td>
<td>B. No educational material or counseling (telephone followup only to ascertain use of screening) (610)</td>
<td>12 months</td>
</tr>
<tr>
<td>Christie et al., 2008</td>
<td>Colorectal Cancer Screening</td>
<td>Hispanic, African American</td>
<td>RCT (21)</td>
<td>Mean age: 58 years Gender: 75% female Race/ethnicity: 71% Hispanic, 21% African American, 8% other</td>
<td>Community Health Center; New York, New York</td>
<td>A. Patient navigator assigned to coordinate scheduling of colonoscopy and discuss risks and benefits (13)</td>
<td>B. No patient navigator (8)</td>
<td>6 months</td>
</tr>
<tr>
<td>Lasser et al., 2011</td>
<td>Colorectal Cancer Screening</td>
<td>Low-income</td>
<td>RCT (465)</td>
<td>Mean age: 61 years Gender: 62% female Ethnicity: White 47%, Black 27%, other 18%, unknown 8%</td>
<td>Community Health Centers; Cambridge, Massachusetts</td>
<td>A. Patient navigator assigned to coordinate scheduling of colonoscopy and discuss risks and benefits (235)</td>
<td>B. Usual care (230)</td>
<td>12 months</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
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<td>Disparity Population</td>
<td>Study Design (N)</td>
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<td>Comparison (n)</td>
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</table>
| Margolis et al., 1998 | Breast and Cervical Cancer Screening | Low-income women | Non-randomized controlled trial (1,693) | Breast cancer screening  
  Age, mean ±SD  
  A. 54.5 ± 11.2  
  B. 55.9 ± 12.0  
  Gender: 100% Female  
  Race, %, A vs. B  
  White: 61 vs. 64  
  African American: 20 vs. 17  
  Native American: 12 vs. 14  
  Other: 7 vs. 5  
  Insurance payer, %, A vs. B  
  Private: 26 vs. 21  
  Medicaid: 46 vs. 46  
  Medicare: 20 vs. 27  
  Self: 8 vs. 5 | Outpatient Primary Care Clinics; Minneapolis, Minnesota | A. Reminders from lay health aides of screenings due, with referral to a culturally sensitive Women's Cancer Screening Clinic (874) | B. No additional contact until followup (819) | 12 months from latest screening due date (12 months for those due at baseline) |
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<tbody>
<tr>
<td>Martin et al., 2006 and 2008</td>
<td>Obesity management</td>
<td>Low-income, African American women</td>
<td>RCT (137)</td>
<td>Mean age: 41.8±12.0 Mean baseline weight: 101.95±19.37kg 100% African American women</td>
<td>Outpatient Primary Care Clinics; Baton Rouge, Louisiana</td>
<td>A. Tailored weight loss intervention delivered by primary care provider including 5 physician counseled office visits on a monthly basis. Included information on weight loss, ways to decrease dietary fat, ways to increase physical activity, barriers to weight loss, healthy food alternatives when eating out or shopping. Total intervention time = 90 minutes (68)</td>
<td>B. Standard care: usual obesity management conducted during a typical office visit (69)</td>
<td>9 to 18 months</td>
</tr>
<tr>
<td>Siddiqui et al., 2011</td>
<td>Colorectal Cancer Screening</td>
<td>African Americans</td>
<td>RCT (1,430)</td>
<td>Mean age: NR (67% were younger than 60 years and 33% were aged 60 or older) Gender: 67% female Ethnicity: 100% African American</td>
<td>Academic primary care practice; Philadelphia, Pennsylvania</td>
<td>A1. Mailed educational intervention-screening invitation, informational booklet, stool blood test, and a reminder letter (362) A2. Mailed educational intervention plus 2 tailored messages addressing personal barriers to screening (349) A3. Mailed educational intervention, tailored messages, and a reminder call (358)</td>
<td>B. Usual care (361)</td>
<td>12 months</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Preventive Service</td>
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</table>
| Thompson et al., 2017 | Cervical cancer screening | Latina, rural | RCT (443) | Low-income Latino women in the Yakima Valley  
Mean age (SD)  
A1. 43.8 (10.4)  
A2. 43.2 (9.3)  
B. 44.6 (9.6) | FQHC in the Yakima area, WA- Yakima Valley Farm Workers Clinic (YVFWC) | A1. Low-intensity intervention: Spanish-language video that was sent to participants' homes, informed women of importance of cervical cancer screening (150)  
A2. High intensity intervention: promotora-led educational session at participants' homes as well as viewing the low-intensity video (146) | B. Usual-care (147): had access to information about cervical cancer and the importance of Pap testing via public health education and from health care provider at FQHC | September 2011 to April 2015; 7 months after randomization |
<table>
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<tbody>
<tr>
<td>Wang et al., 2010</td>
<td>Cervical cancer screening</td>
<td>Low income Chinese-American women</td>
<td>Cohort (134)</td>
<td>Underserved Chinese American women</td>
<td>Community-based organizations (CBO), New York, NY</td>
<td>A. 2 CBOs that offered cervical cancer education combined with patient navigation (80) Education - two education sessions designed to increase knowledge and enhance attitudes towards cervical-cancer screening; participated in an open discussion with a Chinese-speaking physician; received handouts on cervical cancer; watched a Chinese-language video on the subject; and received information about healthcare sites that provided free cervical-cancer screening Patient navigation assistance - arranging Pap test appointments, language translation, transportation assistance, paperwork for obtaining free or low-cost screening</td>
<td>B. 2 CBOs that acted as the control (54) - women received two education sessions on general health and cancer education, received written materials on general health and cancer screening guidelines, and information on healthcare sites that provided free cervical cancer screening</td>
<td>NR; 12 months</td>
</tr>
</tbody>
</table>

**Abbreviations:** CBO = community based organization; CRC = colorectal cancer; FQHC = federally qualified health clinic; kg = kilogram; NR = not reported; Pap = Papanicolaou test; RCT = randomized controlled trial; SD = standard deviation; YVFWC = Yakima Valley Farm Worker’s Clinic

See Appendix B. Included Studies for full citations
<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
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</thead>
<tbody>
<tr>
<td>Ahmed et al., 2010</td>
<td>Completion of screening mammography extracted from medical records</td>
<td>Good</td>
<td>Good</td>
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<td>Mammograms completed, % (n)</td>
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<td></td>
<td>A1: 16% (126)</td>
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<td></td>
<td>A2: 27% (213)</td>
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<td></td>
<td>B: 13% (105)</td>
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<td>RR A1 vs. B: 1.20 (95% CI 0.95 to 1.53)</td>
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<td>RR A2 vs. B: 2.03 (95% CI 1.64 to 2.51), p≤0.001</td>
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<tr>
<td>Bastani et al., 2015</td>
<td>6 months, A vs. B</td>
<td>Fair</td>
<td>Fair</td>
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<tr>
<td></td>
<td>Screening rate, total sample: 15% vs. 10%; OR 1.6 (p=0.006)</td>
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<tr>
<td></td>
<td>Screening rate, whites: 15% vs.10%; OR 1.5 (p=0.182)</td>
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<td></td>
<td>Screening rate, Latinos: 14% vs. 8%; OR 1.7 (p=0.117)</td>
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<td>Screening rate, African Americans: 12% vs. 10%; OR 1.3 (p=0.684)</td>
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<td>Screening rate, Asians: 18% vs. 10%; OR 2.0 (p=0.073)</td>
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<td>12 months, A vs. B</td>
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<td></td>
<td>Screening rate, total sample: 26% vs.18%; OR 1.6 (p=0.001)</td>
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<td>Screening rate, whites: 30% vs. 20%; OR 1.7 (p=0.045)</td>
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<td></td>
<td>Screening rate, Latinos: 24% vs.14%; OR 1.9 (p=0.027)</td>
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<td></td>
<td>Screening rate, African Americans: 23% vs. 22%; OR 1.1 (p=0.906)</td>
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<tr>
<td></td>
<td>Screening rate, Asians: 28% vs. 17%; OR 1.9 (p=0.039)</td>
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<tr>
<td>Christie et al., 2008</td>
<td>Screening rate, A vs. B</td>
<td>Fair</td>
<td>Poor</td>
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<tr>
<td></td>
<td>53.8% vs. 13.0%, p=0.058</td>
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<td>RR, (95% CI): 4.31 (0.64 to 28.84)</td>
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<td>Refused screening, A vs. B</td>
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<td></td>
<td>23% vs. 63%, p=NR</td>
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<tr>
<td></td>
<td>RR not calculable (reported percentages do not correspond to whole patients)</td>
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<tr>
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<tr>
<td>Lasser et al., 2011</td>
<td>Screening rate, A vs. B % (n) 33.6% (79) vs. 20.0% (46) RR (95% CI): 1.68 (1.23 to 2.30)</td>
<td>Fair 1. Unclear allocation concealment.</td>
<td>Fair 1. Patient navigation intervention is resource intensive and may not be plausible in all health systems.</td>
</tr>
<tr>
<td>Margolis et al., 1998</td>
<td>Breast cancer screening rates, A vs. B Overall: 69.3% vs. 62.9%, p=0.009 Due at baseline: 59.9% vs. 50.3%, p=0.006 Up-to-date at baseline: 79.4% vs. 82.1%, p=0.37 Age 40-59 years: 56% vs. 48% Age ≥60 years: 68% vs. 54%, p=0.003 Whites: 55% vs. 55%, p=0.900 African American: 70% vs. 57%, p=0.110 Native American: 55% vs. 33%, p=0.010 Other: 76% vs. 40%, p=0.007, summary p=0.01 Cervical cancer screening rates, A vs. B Overall: 70.3% vs. 62.9%, p=0.02 Due at baseline: 63.2% vs. 50.3%, p=0.002 Up-to-date at baseline: 80.5% vs. 84.3%, p=0.33 Age 40-59 years: 65% vs. 56% Age ≥60 years: 59% vs. 41%, p=0.002 Whites: 62% vs. 51%, p=0.020 African Americans: 66% vs. 71%, p=0.230 Native Americans: 56% vs. 37%, p=0.060 Others: 76% vs. 45%, p=0.040, summary p=0.004</td>
<td>Fair 1. Randomization not adequate. 2. Unclear allocation concealment.</td>
<td>Fair 1. Intervention is resource intensive and may not be plausible in all health systems.</td>
</tr>
<tr>
<td>Martin et al., 2006 and 2008</td>
<td>Weight loss at 9, 12, 18 month followups, A vs. B 9 months: -1.52±3.72kg vs. 0.61±3.37kg, p=0.01 12 months: -1.38±3.72kg vs. -0.16±3.63, p=0.10 18 months: -0.49±3.33kg vs. +0.07±3.75kg, P=0.39</td>
<td>Fair 1. Unclear allocation concealment.</td>
<td>Fair 1. Implemented in a specific population and geographic region, may not be applicable elsewhere.</td>
</tr>
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<tr>
<td>Siddiqui et al., 2011</td>
<td>Screening rates, Whites vs. African Americans</td>
<td></td>
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<tr>
<td>A1+A2+A3: 53% (230/432) vs. 43% (273/637); AOR 1.44 (95% CI 1.12 to 1.86)</td>
<td>Poor 1. Unclear randomization. 2. Unclear allocation concealment. 3. Unclear whether groups were similar at baseline.</td>
<td>Poor 1. Intervention is resource intensive and may not be plausible in all health systems.</td>
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<tr>
<td>B: 33% (48/146) vs. 32% (69/215); AOR 1.01 (95% CI 0.64 to 1.61)</td>
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<tr>
<td>A1: 55% (86/156) vs. 41% (84/206); AOR 1.68 (95% CI 1.10 to 2.58)</td>
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<tr>
<td>A2: 50% (68/135) vs. 40% (86/214); AOR 1.42 (95% CI 0.92 to 2.21)</td>
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<tr>
<td>A3: 54% (76/141) vs. 47% (103/217); AOR 1.25 (95% CI 0.81 to 1.92)</td>
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<tr>
<td>Thompson et al., 2017</td>
<td>Completion of a Pap test within the 7 months after randomization</td>
<td>Fair</td>
<td>Fair 1. The at home promotora visit may not be plausible in all health systems (resource heavy)</td>
</tr>
<tr>
<td>% (n)</td>
<td></td>
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<tr>
<td>A1. 38.7% (58)</td>
<td>Fair 1. Unclear randomization. 2. Unclear allocation concealment.</td>
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<tr>
<td>A2. 53.4% (78)</td>
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<tr>
<td>B. 34% (50)</td>
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<tr>
<td>A2 vs. B, p&lt;0.001</td>
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<tr>
<td>A2 vs. A1, p&lt;0.01</td>
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<tr>
<td>A2 vs. B, p=0.40</td>
<td></td>
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<tr>
<td>Wang et al., 2010</td>
<td>Received screening 12 months after intervention, % (n)</td>
<td>Poor</td>
<td>Good</td>
</tr>
<tr>
<td>A: 70% (56)</td>
<td>Poor 1. Did not enroll consecutive or random sample. 2. Groups were not comparable at baseline. 3. Unclear whether accurate methods were used for confounders and outcomes.</td>
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<td>B: 11.1% (6), p&lt;0.001</td>
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</table>

**Abbreviations:** AOR = adjusted odds ratio; CRC = colorectal cancer; CI = confidence interval; FOBT = fetal occult blood test; kg = kilogram; NR = not reported; OR = odds ratio; Pap = Papanicolaou test; RCT = randomized controlled trial; RR = risk ratio

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<tr>
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<th>Comparison (n)</th>
<th>Duration; Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bennett et al., 2012</td>
<td>Obesity management</td>
<td>Racial and ethnic minorities</td>
<td>RCT (365)</td>
<td>Age, mean: 54.5 Female: 68.5% Race Non-Hispanic Black: 71.2% Non-Hispanic White: 3.6% Hispanic: 13.2% &gt;1 race: 8.5% Medicaid: 33.7% Medicare: 20.5%</td>
<td>Three urban community health centers serving predominantly racial and ethnic minorities in Boston, MA</td>
<td>A. Multi-modal intervention including: 1) 3 tailored behavioral change goals with new goals at 13-week intervals; 2) Patient self-monitoring of progress and receipt of real-time feedback through website or interactive voice response system; 3) Counseling calls delivered by community health educators and optional monthly group sessions; 4) ≥1 brief standardized message from primary care provider; 5) Behavioral skills training materials, information on community resources and a walking kit with pedometer and maps (180)</td>
<td>B. Usual care (185)</td>
<td>Duration: 24 months Followup: 24 months</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
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<tr>
<td>Hendren et al., 2014</td>
<td>Colorectal and breast cancer screening</td>
<td>Low-income</td>
<td>RCT (366; CRC screening=240; mammography =191)</td>
<td>A vs. B CRC Screening Age 50 to 59: 62.3% vs. 61.1% 60+: 37.7% vs. 38.9% Race Black: 43.0% vs. 36.3% White: 52.0% vs. 54.9% Other: 5.0% vs. 8.8% Female: NR Mammography Age 40 to 49: 59.4% vs. 45.6% 50 to 59: 25.7% vs. 23.3% 60+: 14.9% vs. 31.1% Race Black: 41.1% vs. 45.8% White: 47.8% vs. 47.0% Other: 11.1% vs. 7.2% Female: NR</td>
<td>Large safetynet primary care practice; New York</td>
<td>A. Multi-modal intervention including: 1) letters; 2) automated telephone calls; 3) point-of-care prompts reminding clinicians and patients the patient was past due for the service; 4) mailing of home test kit for CRC screening patients (185) Type of CRC screening: colonoscopy, FIT, FOBT</td>
<td>B. Control group (181)</td>
<td>Duration: 6 months Followup: 1 year</td>
</tr>
<tr>
<td>Miller, Jr. et al., 2018</td>
<td>Colorectal cancer screening</td>
<td>Vulnerable patients</td>
<td>RCT (450)</td>
<td>Age, median (range): 57 (50 to 74) Female: 54% Race/ethnicity Non-Hispanic White: 57% African American: 38% Hispanic/Latino: 2% Uninsured: 14% Publicly insured: 42% Income &lt;$20,000: 53%</td>
<td>Six community-based primary care practices within a large health system in North Carolina</td>
<td>A. Mobile Patient Technology for Health-CRC (mPATH-CRC) used an iPad to deliver an 8.6-minute decision aid about CRC screening followed by ability of patient to order screening tests, and if ordered, then patients received followup electronic messages to help complete screening procedures (223)</td>
<td>B. Usual care, receiving a 4.3-minute CDC video about diet and exercise and no option for self-ordering screening tests (227)</td>
<td>Duration: 4.3 to 8.6 minutes for iPad; variable and unclear how long for followup electronic messages Followup: 24 weeks</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
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<td>Disparity Population</td>
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<tr>
<td>Muller <em>et al.</em>, 2017</td>
<td>Colorectal cancer screening</td>
<td>Alaska Native and American Indian People</td>
<td>RCT (808)</td>
<td>Age: 50 to 75 Female: 57.4% Race: 100% Alaska Native and American Indian</td>
<td>Tribally owned and operated healthcare organization offering primary care; Alaska</td>
<td>A. Text message reminders for CRC screening. All patients received screening reminders via telephone, mail, and physicians during in-person visits (404)</td>
<td>B. Standard reminders (404)</td>
<td>Duration: 2 months (up to 3 messages) Followup: 6 months</td>
</tr>
<tr>
<td>Richter <em>et al.</em>, 2015</td>
<td>Tobacco smoking cessation</td>
<td>Rural, Low-income</td>
<td>RCT (566)</td>
<td>Age, mean ± SD: 47.4±12.9 Female: 64.8% Race Caucasian: 82.9% Hispanic/Latino: 9.0%</td>
<td>20 primary care clinics; Kansas</td>
<td>A. Four counseling sessions delivered in the primary care office through telemedicine. Eligible patients in both groups were assisted in applying for cessation medication from pharmacy assistance programs (280)</td>
<td>B. Usual care - telephone cessation counseling (286)</td>
<td>Duration: 3 months (4 sessions) Followup: 6 months</td>
</tr>
<tr>
<td>Simon <em>et al.</em>, 2001</td>
<td>Breast cancer screening</td>
<td>Low-income women</td>
<td>RCT (1,717)</td>
<td>Clinic 1 vs. Clinic 2 Age, range: 40-65+ Female: 100% Race: NR Insurance status Medicaid: 12% vs. 16% Medicare: 12% vs. 12% Commercial: 11% vs. 16% None: 64% vs. 57%</td>
<td>Two Detroit Health Department primary care clinics; Michigan</td>
<td>A1. Letter 1- a physician referral letter, was directed women due for mammography to visit primary care physicians for a mammogram referral (569)</td>
<td>A2. Letter 2- a direct access letter, instructed women to arrange a mammogram directly (591)</td>
<td>B. Usual care - no letter (567)</td>
</tr>
<tr>
<td>Valdez <em>et al.</em>, 2018</td>
<td>Cervical cancer screening</td>
<td>Low-income, Latina women</td>
<td>RCT (943)</td>
<td>Age, mean ± SD: 39.1 ± 11.8 Female: 100% Latina: 100% Foreign-born: 20% Insured: 51% Education, mean ± SD: 8.2 ± 3.8 years</td>
<td>Community clinics in Los Angeles, San Jose, and Fresno, CA</td>
<td>A. Interactive modules delivered in English or Spanish via an electronic, touch-screen kiosk to address cervical cancer knowledge, risk factors, and screening procedures (480)</td>
<td>B. Control group, receiving Spanish or English-language educational material in the mail (463)</td>
<td>Duration: 24 to 28 minutes, mean followup: 6 months</td>
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</table>

**Abbreviations:** CI = confidence interval; CDC = Centers for Disease Control and Prevention; CRC = colorectal cancer; EHR = electronic health record; FIT = fecal immunochemical test; FOBT = fecal occult blood test; IVR = interactive voice response; NR = not reported; OR = odds ratio; Pap = Papanicolaou test; RCT = randomized controlled trial; SD = standard deviation

*See Appendix B. Included Studies for full citations*
| Author, Year  
<table>
<thead>
<tr>
<th>(See Appendix B for full citation)</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
</tr>
</thead>
</table>
| **Bennett et al., 2012** | BMI  
Baseline, mean (SE)  
A. 37.04 (4.96)  
B. 36.99 (5.24)  
Change from baseline at 24 months, mean (SE)  
A. -0.58 (0.14); AUC: -0.54 (0.12)  
B. -0.20 (0.13); AUC: -0.13 (0.11)  
Difference between arms: −0.41 (95% CI -0.73 to -0.09) | | **Fair**  
1. Allocation not concealed  
2. Blinding not possible  
3. Unclear if baseline differences exist | **Fair**  
1. Intervention components difficult to replicate elsewhere  
2. Population likely to be different in other locations  
3. Settings and clinical experience likely to differ |
| **Hendren et al., 2014** | CRC screening  
Unadjusted rates  
A. 37.7%  
B. 16.7%  
p=0.0002  
Adjusted OR: 3.22 (95% CI 1.65 to 6.30)  
Mammography  
Unadjusted rates:  
A. 29.7%  
B. 16.7%  
p=0.034  
Adjusted OR: 1.96 (95% CI 0.87 to 4.39)  
Sub-analysis based on race  
Black vs. White vs. Other  
CRC Screening  
Unadjusted rates  
A: 44.19% vs. 34.62% vs. 20.00%  
B: 14.63% vs. 16.13% vs. 30.00%  
Mammography  
Unadjusted rates  
A: 27.03% vs. 25.58% vs. 60.00%  
B: 10.53% vs. 20.51% vs. 33.33% | | **Fair**  
1. Care providers not masked, unclear if patients masked, attrition and loss to followup not reported | **Good** |
<table>
<thead>
<tr>
<th>Author, Year</th>
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<tbody>
<tr>
<td>Miller, Jr. et al., 2018</td>
</tr>
<tr>
<td>Outcomes</td>
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<tr>
<td>Overall CRC screening rates:</td>
</tr>
<tr>
<td>A. 30.0% (67/223)</td>
</tr>
<tr>
<td>B. 15.0% (34/227)</td>
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<tr>
<td>Percent difference: 15% (95% CI 7 to 23)</td>
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<td>Adjusted odds ratio (usual care=reference): 2.5 (95% CI 1.6 to 4.0)</td>
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<tr>
<th>Outcomes</th>
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<tbody>
<tr>
<td>CRC screening rate by income:</td>
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<tr>
<td>&lt;$20,000/yr vs. ≥$20,000/yr</td>
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<tr>
<td>A. 24.6% (29/118) vs. 37.5% (36/96)</td>
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<tr>
<td>B. 15.0% (17/113) vs. 15.5% (17/110)</td>
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<tr>
<td>Percent difference: 9.6% (95% CI -1 to 20) vs. 22.0% (95% CI 10 to 34)</td>
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</tbody>
</table>

| CRC screening rate by race/ethnicity |
| Non-Hispanic White vs. other race/ethnicity |
| A. 27.2% (34/125) vs. 33.7% (33/98) |
| B. 12.0% (16/133) vs. 19.1% (18/94) |
| Percent difference: 15.2% (95% CI 6 to 25) vs. 14.6% (95% CI 2 to 27) |

| Muller et al., 2017 |
| Completed CRC screening |
| A. 15.6% |
| B. 11.1% |
| HR: 1.42, 95% CI 0.97 to 2.09, p=0.07 |

| Richter et al., 2015 |
| 7-day point prevalence smoking cessation |
| A. 9.8% |
| B. 12.0%, p=0.406 |
| Prolonged abstinence |
| A. 8.1% |
| B. 7.6%, p=0.839 |
| Pharmacotherapy use |
| A. 55.9% |
| B. 46.1%, p=0.03 |

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<th>Quality Rating</th>
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<tbody>
<tr>
<td>Fair</td>
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<td>Good</td>
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<th>Applicability Rating</th>
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<tr>
<td>Good</td>
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<td>Fair</td>
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1. Unclear if groups were similar at baseline
2. Unclear masking of care provider
3. Unclear if authors used intention-to-treat analysis
1. Tailored messaging targeted to specific population in Alaska
2. Patients are ‘customer-owners’ of the clinic
3. Patients receive screening at no cost
4. Sampling frame is of participants who opted in to receive text messages and participate in studies
1. No blinding of patients or providers
2. Blinding of outcome assessors unclear
1. Clinic capacity in terms of costs, staffing, and space to implement intervention may not be replicable
<table>
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<tr>
<th>Author, Year</th>
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</thead>
</table>
| Simon et al., 2001 | Adjusted odd ratio:  
B: Reference (77/567)  
A1: 1.10 (95% CI 0.77 to 1.56)  
A2: 1.28 (95% CI 0.92 to 1.82)  
Receipt of mammogram, Clinic 1  
A1: 19%  
A2: 20%  
B: 17%, p=0.743  
Clinic 2  
A1: 11%  
A2: 14%  
B: 11%, p=0.376 | Poor  
1. Randomization, allocation concealment, and blinding not described  
2. Unclear if groups were similar at baseline. | Fair  
1. Insurance requirements may make the intervention difficult to implement in some places |
| Valdez et al., 2018 | Appointment or receipt of Pap test within 6 months  
A. 79.8% (383/480)  
B. 74.3% (344/463)  
Adjusted OR of patients receiving pap test (n=727): Intervention group OR 1.14 (95% CI 0.84 to 1.55) | Fair  
1. Blinding of patients and outcome assessors not reported  
2. Attrition and post-randomization exclusions not reported | Fair  
1. Sample derived within clinics and intervention targeted to specific population  
2. Followup procedures may not be replicable everywhere |

**Abbreviations:** AUC = area under receiver operating characteristic curve; BMI = body mass index; CI = confidence interval; CRC = colorectal cancer; EHR = electronic health record; HR = hazard ratio; IVR = interactive voice response; NR = not reported; OR = odds ratio; Pap = Papanicolaou test; RCT = randomized controlled trial; SD = standard deviation; SE = standard error  

*See Appendix B. Included Studies for full citation*
Table F-7. Effectiveness of healthcare organization interventions to reduce disparities in preventive services: study characteristics

<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Preventive Service</th>
<th>Disparity Population</th>
<th>Study Design (N)</th>
<th>Population; Age (mean; range); Gender; Race</th>
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<th>Interventions (n)</th>
<th>Comparison (n)</th>
<th>Duration; Followup</th>
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<tbody>
<tr>
<td>Abood, Black &amp; Coster, 2005</td>
<td>Breast cancer screening</td>
<td>Low income</td>
<td>Block RCT (1,104)</td>
<td>A vs. B: Mean age: 56.8 vs 53.8 White: 81% vs 94%, p = 0.0105 Black: 19% vs 6%</td>
<td>County Health Departments, Florida</td>
<td>A. Loss/risk framed messages (incoming calls) (112)</td>
<td>B. Standard messages (992)</td>
<td>6 months</td>
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<tr>
<td>Allen &amp; Bazargan-Hejazi, 2005</td>
<td>Breast cancer screening</td>
<td>African Americans and Hispanic</td>
<td>RCT (430)</td>
<td>Mean age: 51.9 years Gender: 100% female Race/ethnicity: 45% Hispanic, 38% African American, 17% other</td>
<td>Community Health Center in Los Angeles, California</td>
<td>A. Culturally-tailored telephone counseling to overcome barriers (219)</td>
<td>B. No telephone counseling (211)</td>
<td>6 months</td>
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<tr>
<td>Author, Year</td>
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<tr>
<td>Arnold et al., 2016a and 2016b</td>
<td>Colorectal cancer screening</td>
<td>Underserved (FQHC)</td>
<td>Group-randomized trial (961)</td>
<td>*Note: significantly different groups by age (p=0.014), race (p&lt;0.001) (and others, see Table 1)</td>
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<td></td>
<td>A1. Intervention-Nurse Age, mean (SD): 59.2 years (7.5) Female: 77% Race Black: 83% White/Hispanic: 17%</td>
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<td>A2. Intervention-Education Age, mean (SD): 57.8 years (6.5) Female: 79% Race Black: 40% White/Hispanic: 60%</td>
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<td>B. Enhanced usual care Age, mean (SD): 57.7 years (7.5) Female: 75% Race Black: 72% White/Hispanic: 28%</td>
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<td>Printed material, telephone at FQHC; Louisiana</td>
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<td>A1. Clinic nurse provided education and FOBT kit, plus tailored telephone problem solving of barriers, mailed materials, and assistance with scheduling. (404)</td>
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<td>A2. Research assistant provided education, printed materials, and FOBT kit during clinic visit, plus yearly mailed reminders and kit (282)</td>
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<td>B. Enhanced usual care - research assistant provided a recommendation for screening and FOBT kit during clinic visit, plus yearly mailed reminders and kit (275)</td>
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<td>A1. Followup within 2 weeks and then 1 month if no appointment scheduled, plus yearly mailed reminders</td>
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<td>A2 and B. Yearly mailed reminders</td>
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</table>
| Baker et al., 2014 | Colorectal cancer screening | Underserved (FQHC) | RCT (450) | A. Intervention Age, mean (SD): 59.5 years (6.1) Female: 70.2% Race Latino/Hispanic: 87.6% Other: 12.4%  
B. Usual care Age, mean (SD): 59.6 years (5.7) Female: 72.9% Race Latino/Hispanic: 91.1% Other: 8.9% | FQHC; Chicago, Illinois | A. Mailed FOBT/FIT kit, letter from PCP, followed by automated call and text message; second call and text 2 weeks later for non-responders; patient navigation 3 months later for non-responders (225)  
B. Usual care - computerized reminders, standing orders for medical assistants to give patients home FIT, and clinician feedback on CRC screening rates (225) | 2 years  
2 weeks and then 3 months for those not responding to FOBT/FIT |
| Battaglia et al., 2012 | Cervical cancer screening | Low income racial and ethnic minority | Nonrandomized trial (1,763) | Age 18-20: 11% 21-30: 57% 30+: 32% Female: 100% Race African American: 32% Hispanic: 31% White: 30% Other: 7% | 6 FQHCs; Boston, MA | A. Patient navigators contacted patients with abnormal screens by phone. Identified barriers to care, timely completion of diagnostic evaluation. Followup by phone, mail, in-person. PNs were language matched to patients. (3 FQHCs with 959 eligible patients)  
B. Usual care (3 FQHCs with 804 eligible patients) | 1 year |
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<th>Comparison (n)</th>
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<tbody>
<tr>
<td>Blumenthal et al., 2010</td>
<td>Colorectal cancer screening</td>
<td>African-Americans</td>
<td>RCT (369)</td>
<td>*Note: significantly different groups by insurance coverage (p&lt;0.001, see Table 1) A1. Intervention-financial support Age, mean (SD): 65.6 years (10.4) Female: 72.6% A2. Intervention-one on one education Age, mean (SD): 69.2 years (9.1) Female: 76.5% A3. Intervention-group education Age, mean (SD): 68.6 years (11.5) Female: 66.7%</td>
<td>Community-based organizations; Atlanta, Georgia</td>
<td>A1. Financial support Up to $500 for out of pocket expenses, health navigator to assist with transportation, scheduling, payment (84) A2. One on one education Three 45-minute sessions with health educator (98) A3. Group education Four 45-minute sessions with health educator (99)</td>
<td>B. Gift bag at introductory session-pamphlet, list of resources (88)</td>
<td>Up to four weeks of sessions 3 months, and 6 month followup for those not screened by 3 months</td>
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<tr>
<td>Author, Year (See Appendix B for full citation)</td>
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</tbody>
</table>
| Braun et al., 2015 | Breast, cervical, colorectal cancer screening | Native Hawaiian and Filipino | RCT (488) | A. Intervention  
Age, mean: 68.4 years  
Female: 52.9%  
Ethnicity  
Chinese: 0.8%  
Filipino: 37.2%  
Hawaiian: 43.0%  
Japanese: 12.4%  
Other: 7.9%  
B. Control  
Age, mean: 66.7 years  
Female: 53.7%  
Ethnicity  
Chinese: 0.8%  
Filipino: 32.1%  
Hawaiian: 47.2%  
Japanese: 9.8%  
Other: 8.5% | Hospital;  
Moloka‘i, Hawai‘i | A. Patient navigation based on  
*Kukui Ahi* model (242) | B. Control-relevant education from another healthcare entity (246) | 3 years |
| Byrd et al., 2013 | Cervical cancer screening | Hispanic | RCT (613) | NR, but women were of  
Mexican origin and ≥21 years of age | Community settings in El Paso and Houston, Texas and Yakima Valley, Washington | 1-on-1 delivery of AMIGAS program by promotora, including:  
A1. Screening contract, games and activities, video on barriers and facilitators, and flip chart to review video (151)  
A2. All but the video (154)  
A3. All but the flip chart (155)  
B. Usual care at clinic (153) | Women in control group who completed study were offered full program (A) after final followup | Followup 6 months post-intervention |
Age, mean (SD): 57.2 years (6.5)  
A2. PN plus motivational interviewing  
Age, mean (SD): 56.9 years (6.0)  
B. Motivational interviewing  
Age, mean (SD): 58.2 years (7.1) | Telephone navigation with patients recruited from barbershops;  
New York City, New York | A1. Patient navigation with 2+ telephone sessions, including assessment of / managing barriers (234)  
A2. Patient navigation plus motivational interviewing (259) | B. Motivational interviewing (238) | 4 years; 6 months |
<table>
<thead>
<tr>
<th>Author, Year</th>
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<th>Study Design (N)</th>
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<th>Interventions (n)</th>
<th>Comparison (n)</th>
<th>Duration; Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronado et al., 2011</td>
<td>Colorectal cancer screening</td>
<td>Hispanic, underserved</td>
<td>RCT (501)</td>
<td>A1 vs. A2 vs. B</td>
<td>Community-based clinic; King County, Washington</td>
<td>A1. Mail packet plus outreach: Mailed packet, plus 10-min telephone calls from promotoras to remind, educate, and answer questions about screening, followed by 50-min home visits including colon models and flip charts to reinforce education (168)</td>
<td>B. Usual care: no formal prompting of CRC screening (165)</td>
<td>9 months</td>
</tr>
<tr>
<td>Coronado et al., 2016</td>
<td>Breast cancer screening</td>
<td>Hispanic women</td>
<td>Block RCT (536)</td>
<td>Age: Female: 100% Race: 100% Hispanic</td>
<td>FQHCs, Washington</td>
<td>A. A promotora-led, motivational interviewing intervention that included a home visit and telephone followup. (210)</td>
<td>B. Usual care (326)</td>
<td>12 months</td>
</tr>
<tr>
<td>Coronado et al., 2018</td>
<td>Colorectal cancer screening</td>
<td>Underserved</td>
<td>Cluster RCT (41,193)</td>
<td>A vs. B</td>
<td>26 FQHCs; Oregon and California</td>
<td>A. Introductory letter, FIT kit and instructions, reminder letter for patients; process improvement for clinics (13 clinics, 21,134)</td>
<td>B. Usual care (13 clinics, 20,059)</td>
<td>18 months; 12 months</td>
</tr>
<tr>
<td>Davis et al., 2013</td>
<td>Colorectal cancer screening</td>
<td>Underserved</td>
<td>Prospective cohort (961)</td>
<td>Age: 58.4 years (7.3) Female: 77% Black: 67% White/Hispanic: 33%</td>
<td>8 FQHC-associated clinics; Louisiana</td>
<td>A1. Nurse provided education, motivational interviewing, followup calls (404)</td>
<td>B. Usual care-FOBT kit and SASE (275)</td>
<td>3 years; 1 year</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
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<td>Study Design (N)</td>
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<tr>
<td>DeGroff et al., 2017</td>
<td>Colorectal cancer screening</td>
<td>Low-income</td>
<td>RCT (856; analyzed 840)</td>
<td>A. Intervention Age 50 to 54: 53% 55 to 64: 33.9% 65 to 74: 13.1% Female: 55.4% Race Hispanic: 39.2% NH Black: 40.7% NH White: 15.1% Other: 5.0% B. Control Age 50 to 54: 54.4% 55 to 64: 32.3% 65 to 74: 13.3% Female: 58.9% Race Hispanic: 41.7% NH Black: 40.2% NH White: 13.3% Other: 4.8%</td>
<td>Telephone navigation with patients recruited from EHRs at a hospital and community health center; Boston, Massachusetts</td>
<td>A. Patient navigation to address multilevel patient-defined barriers to CRC screening (419) B. Computerized reminders, standing orders for medical assistants to give patients home fecal immunochemical tests (FIT), and clinician feedback on CRC screening rates (421)</td>
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<tr>
<td>Dietrich et al., 2006</td>
<td>Breast, cervical, colorectal cancer screening</td>
<td>Low income</td>
<td>RCT (1,413) 11 sites</td>
<td>Age: 58.1 (5.25) Female: 100% Language Spanish: 61.8% Haitian Creole: 0.3%</td>
<td>Community and Migrant Health Centers; New York City, New York</td>
<td>A. Telephone intervention by prevention care managers. Subjects received an average of 4 calls over 18 months: confirming screening dates, determining readiness to act, providing motivational support, working to prioritize screening, helping to overcome individual barriers. Care managers also scheduled appointments, made reminder calls, provide directions, helped find transportation.</td>
<td>B. A single telephone call during which trial staff answered questions about preventive care, informed women of their usual care status, advised them to obtain needed preventive care from their primary care clinician, and thanked them for their participation.</td>
<td>18 months</td>
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<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
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<tr>
<td>Dietrich et al., 2013</td>
<td>Colorectal cancer screening</td>
<td>Low income women</td>
<td>RCT (2,240)</td>
<td>A. vs. B. Age: 55.8 years vs. 55.8 years Female: 100% Race: NR</td>
<td>3 Medicaid managed care organization plans: New York City, New York</td>
<td>A. Personalized letter, educational materials, list of overdue screenings to share with physician, telephone outreach to address barriers and provide appointment reminders; scheduled appointments only for women requesting help (562)</td>
<td>B. Usual care (1,678)</td>
<td>18 months</td>
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<tr>
<td>Dignan et al., 2014</td>
<td>Colorectal Cancer Screening</td>
<td>Rural</td>
<td>Before-after study (66 practices with 3,844 patient records, 3751 at followup)</td>
<td>Age: 64.8 at baseline; 64.1 at followup Female: 60.5% at baseline; 60.1% at followup Race: NR</td>
<td>Primary care practices; Appalachian Kentucky</td>
<td>A. Academic detailing for providers: screening efficacy, clinical performance measures, patient counseling, and creating a screening-friendly practice environment. (33 practices)</td>
<td>B. No treatment for 6 months (33 practices), offered intervention after 6-month followup</td>
<td>6 months</td>
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<tr>
<td>Enard et al., 2015</td>
<td>Colorectal cancer screening</td>
<td>Low Income, Hispanic</td>
<td>RCT (303)</td>
<td>Age 50 to 64: 75 (24.7%) 65 to 75: 228 (75.3%) Female: 54.8% 100% Hispanic</td>
<td>Telephone navigation with patients recruited from Medicare list and contacts at community-based organizations; Texas</td>
<td>A. Bilingual Tailored Patient Navigation: needs, barriers, services assessed; education about screening guidelines and Medicare’s coverage, navigation around barriers. CMS Demonstration Project (135)</td>
<td>B. Mailed educational materials about screening and risk factors (168)</td>
<td>March 2007 to December 2010</td>
</tr>
<tr>
<td>Fang et al., 2017</td>
<td>Cervical cancer screening</td>
<td>Korean American women</td>
<td>RCT (705)</td>
<td>Mean age control: 53.9 (±11.6) Mean age intervention: 51.9 (±9.5) Female: 100% Korean American: 100%</td>
<td>Churches (community setting); Southeastern Pennsylvania and New Jersey</td>
<td>A. Intervention group: multicomponent program that includes navigation services and bilingual community health educators to address individual beliefs and expectations on cervical cancer screening including perceived risks, perceived benefits, perceived barriers, and cultural norms. (347)</td>
<td>B. Information-only control group: bilingual community health educators deliver general information on health, cancer education, screening guidelines (358)</td>
<td>Duration: February 2009 to December 2014 followup: 12 months</td>
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<tr>
<td>Fiscella et al., 2011</td>
<td>Colorectal and breast cancer screening</td>
<td>Low-income</td>
<td>RCT (469; CRC screening=323; mammography =271)</td>
<td>A vs. B CRC Screening Age 50-59: 63.8% vs. 61.3% ≥60: 36.2% vs. 38.8% Race Black: 18.9% vs. 30.8% White: 68.6% vs. 59.8% Other: 12.6% vs. 9.4% Female: 54.6% vs. 58.1% Mammography Age 40 to 49: 36.6% vs. 40.9% 50 to 59: 42.5% vs. 38.7% ≥60: 20.9% vs. 20.4% Race Black: 25.8% vs. 33.1% White: 66.6% vs. 55.2% Other: 7.6% vs. 11.8%</td>
<td>Large safety net primary care practice; New York</td>
<td>A. Multi-modal intervention delivered by a patient navigator including: 1) Outreach consisting of two letters and a phone call; 2) Mailed kits for insured patients needing CRC screening who did not respond to outreach; 3) Point-of-care prompt sheets for patients and clinicians (CRC screening, n=163; mammography, n=134)</td>
<td>B. Control group (CRC screening, n=160; mammography, n=137)</td>
<td>Duration: 1 year followup: 1 year lookback</td>
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<tr>
<td>Friedman &amp; Borum, 2007</td>
<td>Colorectal cancer screening</td>
<td>African-American</td>
<td>Before-after study (248)</td>
<td>NR, but African-Americans 50 years or older were recruited</td>
<td>Resident clinic; Washington, D.C.</td>
<td>Educational intervention for internal medicine residence: didactic seminars, observation of screening modalities, exam, charting</td>
<td>A. Post-intervention (132)</td>
<td>B. Pre-intervention (116)</td>
</tr>
<tr>
<td>Goldman et al., 2015</td>
<td>Colorectal cancer screening</td>
<td>Underserved</td>
<td>RCT (420)</td>
<td>Age: 57.3 (6.2) Female: 66% Latino: 62.1% White: 15.7% Black: 16.4%</td>
<td>Federally Qualified Community Health Center; Chicago, IL</td>
<td>A. Fecal immunochemical tests (FIT) outreach: mailed to home, followed by calls, texts. 3 months later call from patient navigator. Patient navigator help with appointments for positive FIT</td>
<td>B. Usual care (210)</td>
<td>12 months</td>
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<tr>
<td>Guillame et al., 2017b De Mil et al., 2018</td>
<td>Colorectal cancer screening</td>
<td>Low socioeconomic</td>
<td>Cluster RCT (16,267) *Navigable population only</td>
<td>A vs. B Age, mean (SD): 58.6 years (6.9) vs. 58.8 years (7) Female: 51.5% vs. 51.3% Race: NR</td>
<td>Urban and rural strata of deprivation and affluence; France</td>
<td>A. Introductory letter, telephone calls to address barriers, FOBT kit, potential for home visit (8121)</td>
<td>B. Usual care; FOBT kit (8146)</td>
<td>9 months</td>
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<tr>
<td>Gupta et al., 2013</td>
<td>Colorectal cancer screening</td>
<td>Underserved</td>
<td>RCT (5,994)</td>
<td>Age, mean: 59 years Female: 64% White: 41% Black: 24% Hispanic: 29% Other: 7%</td>
<td>Safety-net system; Texas</td>
<td>A1. Colonoscopy: mailed invitation, 2 automated reminder phone calls, 2 'live' reminder phone calls, assistance with scheduling and prep (480) A2. FIT: same as (A1), plus mailed FIT kit (1,600)</td>
<td>B. Usual care - gFOBT, colonoscopy, barium enema, or sigmoidoscopy (3,914)</td>
<td>1 year</td>
</tr>
<tr>
<td>Hendren et al., 2014</td>
<td>Colorectal and breast cancer screening</td>
<td>Low-income</td>
<td>RCT (366; CRC screening n=240; mammography n=191)</td>
<td>A vs. B CRC Screening Age 50 to 59: 62.3% vs. 61.1% 60+: 37.7% vs. 38.9% Race Black: 43.0% vs. 36.3% White: 52.0% vs. 54.9% Other: 5.0% vs. 8.8% Female: NR Mammography Age 40 to 49: 59.4% vs. 45.6% 50 to 59: 25.7% vs. 23.3% 60+: 14.9% vs. 31.1% Race Black: 41.1% vs. 45.8% White: 47.8% vs. 47.0% Other: 11.1% vs. 7.2% Female: NR</td>
<td>Large safety net primary care practice, Rochester, New York</td>
<td>A. Multi-modal intervention including: 1) letters; 2) automated telephone calls; 3) point-of-care prompts reminding clinicians and patients the patient was past due for the service; 4) mailing of home test kit for CRC screening patients (185) Type of CRC screening: colonoscopy, FIT, FOBT</td>
<td>B. Control group (181)</td>
<td>Duration: 6 months followup: 1 year</td>
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<td>Honeycutt et al., 2013</td>
<td>Colorectal cancer screening</td>
<td>Underserved</td>
<td>Prospective cohort (809)</td>
<td>Age, mean: 55.8 years Female: 67.1% White: 37.1% Black: 62.9%</td>
<td>13 FQHCs; Georgia</td>
<td>A. Four clinics with Community Cancer Screening Program: health navigators conduct chart audits, manage provider reminder systems, coordinate screening and followup, provide patient education and appointment reminders, assist in overcoming barriers to screening, coordinate provider feedback on referral patterns (289)</td>
<td>B. Nine comparison clinics - no Community Cancer Screening Program (520)</td>
<td>18 months</td>
</tr>
<tr>
<td>Horne et al., 2015</td>
<td>Colorectal cancer screening</td>
<td>African Americans</td>
<td>RCT (1,691)</td>
<td>A vs. B Age 65-69: 49.8% vs. 50.3% 70-75: 50.2% vs. 49.7% Female: 72.8% vs. 72.3%</td>
<td>Unclear; CMS-funded multisite trial, with this site in Baltimore associated with Johns Hopkins</td>
<td>A. Patient navigation to identify and overcome barriers to screening, plus printed education materials (578) Type of CRC screening: FOBT or colonoscopy / flexible sigmoidoscopy</td>
<td>B. Printed educational materials from CMS and ACS on general cancer information and Medicare services (642)</td>
<td>Duration: 4 years Followup: 1 year (FOBT), any point within prior 10 years (C/FS)</td>
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<tr>
<td>Jandorf et al., 2005</td>
<td>Colorectal cancer screening</td>
<td>Underserved</td>
<td>RCT (78)</td>
<td>Age, mean (SD): 61.2 years (7.8) Female: 74.4% Hispanic: 82.1%</td>
<td>1 FQHC; New York City, New York</td>
<td>A. Telephone patient navigation by research assistant: patient education, assessment of barriers, followup (38)</td>
<td>B. Usual care- not navigated (40)</td>
<td>6 months</td>
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<tr>
<td>Jandorf et al., 2014</td>
<td>Cervical and breast cancer screening</td>
<td>Latinas</td>
<td>Cluster RCT (1,333)</td>
<td>Mean age NR Female: 100% Latino: 100%</td>
<td>Community based settings in Arkansas, Buffalo, and New York City</td>
<td>A. Faith-based intervention using of peer/lay health workers (LHA, promotoras) (803)</td>
<td>B. Diabetes prevention education group vs. breast and cervical cancer education group (530)</td>
<td>Duration: 2007 to 2009 followup: 2 months, 8 months</td>
</tr>
<tr>
<td>Kim &amp; Sarna, 2004</td>
<td>Breast cancer screening</td>
<td>Korean Americans</td>
<td>Cluster RCT (141)</td>
<td>Mean age: 48 years Gender: 100% female Ethnicity: 100% Korean American</td>
<td>Churches in Los Angeles County, California</td>
<td>A1. Peer-group education about breast cancer screening and access to free or low-cost mobile mammography service (47) A2. Mobile mammography access only (48)</td>
<td>B. Cholesterol education with low-cost blood chemistry and osteoporosis screening (46)</td>
<td>2 months</td>
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<tr>
<td>Lee-Lin et al., 2015</td>
<td>Breast cancer screening</td>
<td>Low income, Chinese American</td>
<td>RCT (300)</td>
<td>Age 58.8 (40 to 85) 100% Female 100% Chinese</td>
<td>Asian health clinic in Portland, Oregon metro area</td>
<td>A. Culturally responsive targeted breast health educational program (TBHEP) (147)</td>
<td>B. Brochure control (153)</td>
<td>3, 6, 12 months</td>
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</table>
| Levy et al., 2013 | Colorectal cancer screening | Rural | RCT (743) | Mean age: 61.1 years Female: 52% Race: 98.7% White, 0.5% Black, 0.8% unknown | Rural family medicine clinics (n=16); Iowa | A1. All materials in (A2) and (A3), plus structured telephone call providing education, assessment and addressing of barriers (187)  
A2. Chart reminder, plus educational materials, fridge magnet, FIT with SASE (186)  
A3. Chart reminder - paper or electronic, depending on clinic system (185) | B. Usual care (185) | 15 months |
| Ma et al., 2009 | Colorectal cancer screening | Korean Americans | Nonrandomized trial (167) | Mean age: 63 years Gender: 59% female Ethnicity: 100% Korean American | Churches; Los Angeles, CA | A. Small group colorectal cancer screening education and patient navigation (84) | B. Small group general health and primary prevention education, without navigation (83) | 12 months |
| Marshall et al., 2016 | Breast cancer screening | African American older adults | RCT (1,358) | >75: 29.3% ≤ 75: 70.7% Female: 100% AA/Black: 100% | Community settings (senior centers, health fairs); Baltimore City, MD | A. CMS developed Patient Education Materials plus Navigation -phone call to address screening status, materials, perceptions/beliefs, barriers; helped arrange appointments and accompanied when necessary. Coached patients on questions to ask providers, Navigators also worked to enhance the patient-provider interaction by coaching patients on potential questions to ask their providers. Phone and in-person contact, minimum quarterly. (638) | B. CMS developed patient education materials (720) | Duration: NR  
Followup, mean: 17.8 months |
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<tr>
<td>Mehta et al., 2016</td>
<td>Colorectal cancer screening</td>
<td>Racial and ethnic minority</td>
<td>Before-after study (868,934)</td>
<td>A1: Post-program 2010 to 2013 Age 50 to 55: 34.8% 56 to 60: 24.6% 61 to 65: 17.5% 66 to 70: 12.9% 71 to 75: 10.1% Female: 54.6% Race NH white: 59.4% NH black: 8.2% Hispanic: 13.3% API: 14.4% Native American: 0.5% Multiple: 4.1% A2: Post-program 2007-2009 Age 50 to 55: 35.7% 56 to 60: 25.8% 61 to 65: 16.1% 66 to 70: 12.2% 71 to 75: 10.3% Female: 54.1% Race NH white: 60.9% NH black: 8.1% Hispanic: 12.5% API: 13.7% Native American: 0.5% Multiple: 4.3%</td>
<td>Mail, community-based healthcare system; Kaiser Permanente Northern California</td>
<td>Mailed FIT kits to overdue patients (outreach), EMR prompts during clinic visits (in-reach) A1. After program: 2010 to 2013 (665,268) A2. After program: 2007 to 2009 (654,633) Note: cohorts overlap</td>
<td>Screening status pre-program implementation, screening status immediately after program implementation B. Before program: 2004 to 2006 (662,872) Note: cohorts overlap</td>
<td>Duration: 10 years' duration; between 1 and followup: between 1-10 years</td>
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<td>Mehta et al., 2016 (continued)</td>
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<td>(continued)</td>
<td>B: Pre-program 2004 to 2006 Age 50 to 55: 54.8% 56 to 60: 15.6% 61 to 65: 12.2% 66 to 70: 10.6% 71 to 75: 6.8% Female: 54.1% Race NH white: 63.1% NH black: 7.9% Hispanic: 11.5% API: 12.6% Native American: 0.5% Multiple: 4.5%</td>
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<tr>
<td>Miller et al., 2013</td>
<td>Cervical cancer screening</td>
<td>Low-income, racial and ethnic minority women</td>
<td>RCT (211)</td>
<td>A1. Tailored telephone Age, mean (SD): 28.5 years (8.5) Race White: 5.2% Black: 86.2% Hispanic: 8.6% Other: 0% A2. Tailored print Age, mean (SD): 30.7 years (12.0) Race White: 1.4% Black: 84.7% Hispanic: 12.5% Other: 1.4%</td>
<td>University-affiliated clinic serving low-income minority women in Philadelphia, Pennsylvania</td>
<td>A1. Tailored telephone (61) A2. Tailored printed messaging (76)</td>
<td>B. Enhanced standard care - baseline surveys, barriers assessment, mail and telephone appointment reminder (73)</td>
<td>Screening to 6- and 12-month followup appointment; followed up to 15 months</td>
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<tr>
<td>Mitchell, Andrews, &amp; Schenker, 2015</td>
<td>Obesity in adults: screening and management</td>
<td>Latino, low-income, immigrant</td>
<td>RCT (254; analyzed 178)</td>
<td>A. Intervention Age, mean (SD): 32.3 y (7.6) BMI: 29.1 kg/m² (0.3) B. Control Age, mean (SD): 32.5 y (7.9) BMI: 27.7 kg/m² (0.4)</td>
<td>Worksite-sponsored clinic on berry farms in California</td>
<td>Nine 90-minute educational sessions and one final review on PA, healthy weight, healthy diet, lifestyle, plus 15-20 min per session for guided PA (112 analyzed)</td>
<td>A1. Intervention high attendance- 8 to 10 sessions (86) A2. Intervention low attendance- 3 to 7 sessions (26)</td>
<td>B. Control group- no information, contacted only once to maintain communication (66 analyzed)</td>
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| Myers et al., 2014                            | Colorectal cancer screening | African-American | RCT (764) | A. Tailored intervention Age 50 to 59: 75.1% 60+: 24.9% Female: 72.7%  
B. Comparison Age 50 to 59: 67.3% 60+: 32.7% Female: 64.1% | University-and network-affiliated primary care clinics; Philadelphia, Pennsylvania | A. Tailored intervention - mailed CRC screening booklet, personalized message based on identified barriers, colonoscopy contact number or SBT kit, patient navigation (384; analyzed: 382; navigated: 293)  
B. Standard - mailed CRC screening booklet, personalized letter, colonoscopy number, SBT kit, no patient navigation (380; analyzed: 379) | 4 years; 6- and 12-month followups |
| Nash et al., 2006                             | Colorectal cancer screening | Low income racial and ethnic minority | Before-after study (1767) | Age <50:  
A: 12%  
B: 15%  
50 to 54  
A: 17%  
B: 16%  
55 to 59  
A: 21%  
B: 17%  
60 to 64  
A: 20%  
B: 15%  
65 to 69  
A: 15%  
B: 16%  
70 to 74  
A: 9%  
B: 11%  
>75  
A: 6%  
B: 9% | Public hospital; New York City, NY | A. After intervention- August 2003 to February 2004 Patient navigator, direct endoscopic referral system, GI suite enhancements (1297)  
B. Before intervention - April to July 2003 (470) | Duration: March 2003 to February 2004 Followup: same time period (11 months) |
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<td>Nash et al., 2006 (continued)</td>
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<td>(continued)</td>
<td>Female A: 61% B: 59% Race/ethnicity NH Black A: 6% B: 17% Hispanic A: 69% B: 79% Other/unknown A: 25% B: 5%</td>
<td>(continued)</td>
<td>(continued)</td>
<td>(continued)</td>
<td>12 weeks</td>
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<tr>
<td>Navarro et al., 1998</td>
<td>Cervical and breast cancer screening</td>
<td>Low income Hispanic</td>
<td>RCT (512)</td>
<td>Age: 34 (18 to 72) Female: 100% Hispanic: 100%</td>
<td>Community Settings in San Diego County, California</td>
<td>A. Lay Health Worker: identified &quot;consejeras&quot; or &quot;natural helpers&quot; in the community. Consejeras led weekly education sessions to women in their social networks. Culturally appropriate educational materials. (274)</td>
<td>B. Control - Consejeras led weekly &quot;Community Living Skills&quot; education. (238)</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Nguyen et al., 2015</td>
<td>Colorectal cancer screening</td>
<td>Vietnamese-American</td>
<td>RCT (640)</td>
<td>Age 50 to 64: 67.8% vs. 75% 65 to 74: 32.2% vs. 25% Female: 50% Vietnamese: 100%</td>
<td>Community-based organizations; Santa Clara County, California</td>
<td>A. Navigation- lay health workers provided CRC education using a flip chart created for the intervention in Vietnamese. Followup calls, in person visits, referrals to low cost screening, assistance with making appointments, accompanying subject to appointment at times. (320)</td>
<td>B. Lay health worker education about healthy eating, physical activity, followup calls/visits to remind them to exercise and eat healthy. (320)</td>
<td>6 months</td>
</tr>
<tr>
<td>Percac-Lima et al., 2009</td>
<td>Colorectal cancer screening</td>
<td>Low income minority</td>
<td>RCT (1,223)</td>
<td>Age, mean: 63 years Female: 60% White: 47% Latino: 40% Black: 5% Asian: 2%</td>
<td>Hospital-affiliated primary care clinic; Chelsea, Massachusetts</td>
<td>A. Patient navigation: introductory letter, educational materials, assessment and addressing of barriers to screening, appointment scheduling and reminders, bowel prep assistance, transportation and appointment attendance as needed (409)</td>
<td>B. Usual care; patients given access to (A) after study completion (814)</td>
<td>9 months</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
<td>Setting</td>
<td>Interventions (n)</td>
<td>Comparison (n)</td>
<td>Duration; Followup</td>
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<tr>
<td>Percac-Lima et al., 2012</td>
<td>Breast cancer screening</td>
<td>Serbo-Croatian (Bosnian) speaking self-identified</td>
<td>Before-after study (91)</td>
<td>Age, mean (range): 54 years (40-78) Female: 100% Race: NR Serbo-Croatian speaking: 100%</td>
<td>Hospital-affiliated Community Health Center, Chelsea, MA</td>
<td>Culturally tailored patient navigation. In person, phone, organized educational group sessions in community setting. Explored barriers, talked about preventive care. Arranged transportation, reminder calls, scheduling appointments, resolving insurance issues, accompanying patients to appointments when needed.</td>
<td>A. After intervention (91)</td>
<td>B. Before intervention (91)</td>
</tr>
<tr>
<td>Percac-Lima et al., 2014</td>
<td>Colorectal cancer screening</td>
<td>Latino Non-English speakers, non-Latino</td>
<td>Before-after study (3,115)</td>
<td>Age, mean (SD): 61.4 years (6.7) Female: 57.1% Race/ethnicity Asian: 1.8% Black: 5.2% Latino: 39.5% White: 49.6% Other: 4.0%</td>
<td>Hospital-affiliated community health center; Philadelphia, Pennsylvania</td>
<td>Culturally tailored patient navigation, including assessment/management of barriers</td>
<td>A. After intervention (NR)</td>
<td>B. Before intervention (NR)</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
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<tr>
<td>Phillips et al., 2011</td>
<td>Breast cancer screening</td>
<td>Low-income, racial and ethnic minority women</td>
<td>RCT (3,895)</td>
<td>*Note: significantly different by race, p&lt;0.001</td>
<td>Safety-net hospital-affiliated internal medicine clinics in Boston, Massachusetts</td>
<td>A. Patient navigation as part of the primary care team, including assessment of/ addressing individual barriers to care (1,817)</td>
<td>Concurrent comparison group- received intervention at end of study (2,078)</td>
<td>9 months, followed until receipt of mammogram or end of protocol</td>
</tr>
<tr>
<td>Powell et al., 2005</td>
<td>Breast cancer screening</td>
<td>Rural African Americans</td>
<td>Cluster RCT (192)</td>
<td>Mean age: NR (75% were younger than 65 years and 25% were 65 years or older) Gender: 100% female Ethnicity: 100% African American</td>
<td>Churches, Greene County, AL</td>
<td>A1. Full program - educational intervention, including videos, group discussion (partial and full intervention groups), and a home visit by a home health educator (full intervention group only) (75) A2. Partial program - educational intervention, including videos and group discussion (partial and full intervention groups) only (71)</td>
<td>B. Delayed intervention (44)</td>
<td>3 months</td>
</tr>
<tr>
<td>Reuland et al., 2017</td>
<td>Colorectal cancer screening</td>
<td>Low-income, racial and ethnic minority</td>
<td>RCT (265)</td>
<td>Mean age: 58 years (50-75) Female: 65% Race Latino: 62% Non-Latino White: 15% Non-Latino Black/Mixed: 23%</td>
<td>2 community health centers, one each in Albuquerque, New Mexico and Charlotte, North Carolina</td>
<td>A. Tailored patient navigation using CRC screening decision aid videos regarding FOBT/FIT or colonoscopy, distribution of FOBT/FIT kits (133)</td>
<td>B. Food safety videos (attention control), usual care (132)</td>
<td>6 months</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
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<tr>
<td>Roetzheim et al., 2004 and 2005</td>
<td>Breast, cervical, colorectal cancer screening</td>
<td>Low income</td>
<td>Cluster RCT (1,196) 8 Practices</td>
<td>Age 50 to 56: 37.1% 57 to 63: 33% 64 to 75: 29.8% Female: 78.2% Race AA/Black: 29.1% White: 48.4% Hispanic: 22.5%</td>
<td>8 clinics; Hillsborough County, Florida</td>
<td>A. Cancer screening checklist completed by patients. stickers to designate whether screening was ordered/completed. (600) Type of CRC screening: FOBT</td>
<td>B. Usual care (596)</td>
<td>12 months and 24 months</td>
</tr>
<tr>
<td>Rosas et al., 2015</td>
<td>Obesity in adults: screening and management</td>
<td>Low income, Latino</td>
<td>RCT (207)</td>
<td>Age, mean (SD): 47.1 years (11.1) Female: 76.8% Race: 100% Latino</td>
<td>1 health system-affiliated community health center; Fair Oaks, California</td>
<td>A1. Case management plus community health worker: (A2) plus fostering family support, building skills for navigating obesogenic environment, mapping neighborhood walking routes, modified photovoice activities to track and manage food and physical activity and goals. (A2) group and individual sessions, plus five home visits first year, two home visits second year. (82) A2. Case management: motivational interviewing, goal-setting, cooking and PA demonstrations, fostering self-efficacy, identifying community resources, coordinating with primary care. First year 12 (2-hr) group and 4 (30-min) individual sessions; second year 3 group and 1 individual session. (84)</td>
<td>B. Usual care, with potential for referral to lifestyle counseling in specialized diabetes clinic; access to modified (A2) at study completion. (41)</td>
<td>2 years</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
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<tr>
<td>Singal et al., 2016</td>
<td>Colorectal cancer screening</td>
<td>Underserved</td>
<td>RCT (5,999)</td>
<td>Mean age: 56 years Female: 62% White: 22% Hispanic: 49% Black: 24%</td>
<td>Safety-net hospital system; Dallas County, Texas</td>
<td>A1. Mailed letter with invitation, telephone call reminder for nonresponders, phone number to call for scheduling, mailed bowel prep, appointment reminder phone call for colonoscopy (2,400) A2. Mailed letter with invitation, telephone call reminder for nonresponders, FIT kit and SASE, instructions (2,400)</td>
<td>B. Usual care for colonoscopy or FIT (1,199)</td>
<td>3 years; 1 year</td>
</tr>
<tr>
<td>Staten et al., 2004 Arizona WISEWOMAN</td>
<td>Obesity in adults: screening and management</td>
<td>Hispanic, underserved</td>
<td>RCT (217)</td>
<td>Mean age (SD): 57.2 years (4.8) Female: 100% Race White: 25% Hispanic: 74% AA/Black: 1%</td>
<td>2 national Breast and Cervical Cancer Early Detection Program clinics; Tucson, Arizona</td>
<td>A1. PC+HE+CHW (67): (A2) and (B), plus semweekly to monthly communication with a community health worker providing advice on healthy diet and exercise, behavior change, and invitations to bimonthly walks in community. A2. PC+HE (73): (B), plus two health education classes (one on nutrition, one on physical activity), monthly health newsletter for 12 months, reminder calls at 6 months.</td>
<td>B. PC (77): provider counseling (active control), including brochures, benefits of physical activity and healthy diet, behavior change prescription tailored to individual</td>
<td>12 months</td>
</tr>
<tr>
<td>Author, Year</td>
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</table>
| Stoddard et al., 2004 Massachusetts WISEWOMAN | High blood pressure screening | Underserved | RCT (1,443) | Age, years (50-64): 82.9%  
Age, years (≥65): 17.1%  
Female: 100%  
Race  
White: 79.4%  
AA/Black: 2.7%  
Hispanic: 11.7%  
Other: 6.2% | 10 Massachusetts Breast and Cervical Cancer Initiative project sites; Massachusetts | A. EI (n=NR): enhanced intervention, including (B) plus lifestyle interventions focused on nutrition and physical activity to reduce CVD risk through one-to-one assessment and counseling, individual and group education, activities in the community | B. MI (n=NR): minimal intervention, including screening for breast and cervical cancer, CVD risk factors, multiple risk factors, counseling and education, referrals, and follow up; low-literacy fact sheets on preventive services | 12 months |
| Taplin et al., 2008 | Colorectal, breast, cervical cancer screening | Underserved | Before-after study (97,433) 4 Sites | Female: 49.5%  
Race  
Asian: 1.6%  
AA/Black: 14.6%  
AI/AN: 0.3%  
White: 21.2%  
Hispanic: 58.9% | 4 FQHCs; U.S. nationwide | “Care process leaders,” worked with primary care teams to plan and implement practice changes. FQHCs monitored progress: self-management goal-setting; number and percent screened for breast, cervical, and colorectal cancer; percent timely results notification; and percent abnormal screens evaluated within 90 days. Create local communities of practice (LCOP) involving community resources to support cancer screening.  
Type of CRC screening: colonoscopy, sigmoidoscopy, FOBT | B. Before intervention (NR) | 15 months |
<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
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<th>Comparison (n)</th>
<th>Duration; Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tu et al., 2006</td>
<td>Colorectal cancer screening</td>
<td>Chinese Americans</td>
<td>RCT (210)</td>
<td>A vs. B Age 50-64: 59.1% vs. 49.5% 65+: 40.9% vs. 50.5% Female: 63.8% vs. 61.9% Race: 100% Chinese American</td>
<td>1 community clinic serving primarily Asians; Seattle, Washington</td>
<td>A. CRC screening education from health educator, video, and pamphlet, FOBT kit with instructions, plus SASE (105)</td>
<td>B. Usual care (105)</td>
<td>6 months</td>
</tr>
<tr>
<td>Weber &amp; Reilly, 1997</td>
<td>Breast cancer screening</td>
<td>Low-income, racial and ethnic minority</td>
<td>RCT (376)</td>
<td>A vs. B Age, mean: 63 years vs. 63 years Race White: 39.8% vs. 43.7% Black: 39.2% vs. 33.2% Hispanic: 4.3% vs. 9.5% Asian: 3.8% vs. 4.2%</td>
<td>6 hospital-affiliated primary care practices; Rochester, New York</td>
<td>A. Mailed personalized letter from PCP, mailed personalized letter from community health worker 2 weeks later, CHW navigation (telephone, home visit, mail, office visits; education, appointment reminders, assessment and management of barriers, appointment scheduling / transport, financial assistance, dependent care) (186)</td>
<td>B. Mailed personalized letter from PCP, usual care (190)</td>
<td>16 weeks</td>
</tr>
<tr>
<td>West et al., 2004</td>
<td>Breast cancer screening</td>
<td>Low-income, African-American women</td>
<td>Multi-stage RCT: randomized first to stage 1, then independent of stage 1 group, if not screened they were randomized to stage 2 Stage 1 (320) Stage 2 (237)</td>
<td>Age, mean: 65 years Black: 91%</td>
<td>FQHC in rural Alabama locations</td>
<td>Stepped-care intervention (personalized letter in Stage 1, personalized phone counseling in Stage 2) A1. Stage 1 - letter (159) A2. Stage 2 - counseling call (119)</td>
<td>B1. Stage 1 - usual care (161) B2. Stage 2 - letter (118)</td>
<td>1 year; 6 month followup for each stage</td>
</tr>
<tr>
<td>Wu &amp; Lin, 2015</td>
<td>Breast cancer screening</td>
<td>Chinese women</td>
<td>RCT (193)</td>
<td>Age: 54.6 (9.6) Female: 100% Chinese: 100%</td>
<td>Community Settings in Michigan</td>
<td>A. Tailored Intervention: telephone intervention tailored to the results of a baseline survey about barriers, misconceptions, risks. (96)</td>
<td>B. NCI mammography brochure (97)</td>
<td>4 months</td>
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**Abbreviations:** AA = African American; ACS = American Cancer Society; AI/AN = American Indian/Alaskan Native; AMIGAS = Ayudando a las Mujeres con Informacion, Guia, y Amor para su Salud; API = Asian-Pacific Islander; BMI = body mass index; C/FS = colonoscopy/flexible sigmoidoscopy; CMS = Centers for Medicare and Medicaid Services; CRC = colorectal cancer; EHR = electronic health record; EMR = electronic medical record; FIT = fecal immunochemical test; FOBT = fecal occult blood test; FQHC = Federally Qualified Health Center; gFOBT = guaiac fecal occult blood test; RCT = randomized controlled trial; SASE = Screening Assistance and Support; CHW = Community Health Worker.
occult blood test; kg/m² = kilogram per meter squared; LCOP = local communities of practice; LHA = lay health advisors; MINT = motivational interviewing for blood pressure control; NCI = National Cancer Institute; NH = non-Hispanic; NR = not reported; PA = physical activity; PCP = primary care provider; PLUS = patient navigation plus motivational interviewing; PN = patient navigation; RCT = randomized controlled trial; SASE = self-addressed stamped envelope; SBT = stool blood test; SD = standard deviation; TBHEP = targeted breast health educational program

See Appendix B. Included Studies for full citations
### Table F-8. Effectiveness of healthcare organization interventions to reduce disparities in preventive services: outcomes

<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
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</thead>
<tbody>
<tr>
<td>Abood, Black &amp; Coster, 2005</td>
<td>Mammogram completion in 6 months (adjusted for race and breast cancer symptoms): AOR = 1.914 (95% CI 1.2 to 3.05), p=0.0063</td>
<td>Poor</td>
<td>Poor</td>
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</table>
|                                                | 1. Randomization not sufficient  
2. Not comparable groups at baseline  
3. Maintenance of comparable groups unclear  
4. No reporting of attrition/Loss to follow up unclear  
5. ITT unclear  
6. Post randomization exclusions unclear     |                |                     |
| Allen & Bazargan-Hejazi, 2005                   | Mean screening utilization rate  
A. 36.8%  
B. 29.0%, p=NS                                                  | Fair           | Fair                |
|                                                | 1. Unclear as to whether outcome assessors were masked                                                           |                |                     |
| Arnold et al., 2016b                            | Completion of three FOBT kits  
A1. 13.6%  
A2. 11.4%  
B. 4.7%  
p=0.005                                                  | Poor           | Poor                |
|                                                | 1. Groups not comparable at baseline  
2. Unclear whether outcome assessors were masked  
3. Unclear whether attrition or loss to followup occurred |                |                     |
|                                                | Screening ratio, A1 vs. A2, (95% CI): 1.11 (0.76 to 1.62), p>0.05  
Screening ratio, A1 vs. B, (95% CI): 2.65 (1.47 to 4.77), p=0.001  
Screening ratio, A2 vs. B, (95% CI): 2.39 (1.21 to 4.72), p=0.01 |                |                     |
| Baker et al., 2014                              | Completion of FOBT within 6 months (2014)  
A. 82.2%  
B. 37.3%  
p<0.001  
NNT: 2.2                          | Fair           | Fair                |
|                                                | 1. Unclear allocation concealment  
2. Unclear masking                                                                                   |                |                     |
<p>|                                                | Note: in 2015 followup, 88.7% of those in Group A kept up to date on CRC testing                        |                |                     |</p>
<table>
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<tr>
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</thead>
</table>
A. 79.1% vs. 87.9%, p=0.0008  
B. 80.0% vs. 78.6%, p=0.64  
Median days to resolution  
A. 110 vs. 76, p=NR  
B. 84 vs. 90, p=NR  
Adjusted HR for time to resolution during intervention time period compared with baseline time period  
A. 1.45 (95% CI 1.14 to 1.88), p=0.003  
B. reference | Fair  
1. Groups not similar at baseline  
2. Unclear masking | Fair  
1. Specialized skills of patient navigator  
2. Language concordance |
| Blumenthal et al., 2010 | Any type of CRC screening by 6 months (ITT)  
A1. 16.7%  
A2. 17.4%  
A3. 22.2%  
B. 12.5%  
*No groups significant vs. control  
Screening by 6 months, contacted, n=257  
A1. 22.2%  
A2. 25.4%  
A3. 33.9%  
B. 17.7%  
*A3 vs. B, p=0.04 | Poor  
1. Unclear whether randomization was adequate  
2. Unclear whether allocation concealment was adequate  
3. Unclear outcome assessors or care providers were masked  
4. Groups not comparable re: insurance status at baseline  
5. High attrition | Poor  
1. Study population (inclusion/exclusion, demographics, adherence, recruitment, refusal)  
2. Study setting (system, time, cost, effort, center)  
3. Study providers (training, expertise) |
<table>
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<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
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<tbody>
<tr>
<td>Braun et al., 2015</td>
<td>FOBT within past 1 year</td>
<td>A. 20.7%</td>
<td>Poor</td>
</tr>
<tr>
<td></td>
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<td>B. 12.6%</td>
<td>1. Unclear whether allocation concealment was adequate</td>
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<td>p=0.02</td>
<td>2. Outcome assessors were not masked</td>
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<td>Endoscopy within past 5 years</td>
<td>A. 43.0%</td>
<td>3. No reporting of attrition and loss to followup unclear</td>
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<td></td>
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<td>B. 27.2%</td>
<td>Poor</td>
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<td></td>
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<td>p&lt;0.001</td>
<td>1. Study population (demographics)</td>
</tr>
<tr>
<td></td>
<td>Pap smear within past 2 years</td>
<td>A. 57.0%</td>
<td>2. Study setting (center)</td>
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<td>B. 36.4%</td>
<td>3. Study providers (training, skill, ancillary providers)</td>
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<td>p=0.001</td>
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<td>Mammogram within past 1 year</td>
<td>A. 61.7%</td>
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<td>B. 42.4%</td>
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<td>p=0.003</td>
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</tbody>
</table>
| Author, Year  
(See Appendix B for full citation) | Outcomes | Quality Rating | Applicability Rating |
|--------------------------------|----------|----------------|---------------------|
| Byrd et al., 2013 | ITT analysis, n=613  
Pap test at 6 months followup, self-report  
A1. 52.3%  
A2. 45.5%  
A3. 41.3%  
B. 24.8%  
p<0.001 between intervention groups and control group  
p>0.05 among intervention groups  
Pap test at 6 months followup, validated by medical records  
A1. 17.9%  
A2. 22.7%  
A3. 19.4%  
B. 7.2%  
p=0.008 between intervention groups and control group  
p>0.05 among intervention groups  
Pap test at 6 months, El Paso, validated  
A1. 0%  
A2. 4.0%  
A3. 10.0%  
B. 8.0%  
p>0.05 for all comparisons  
Pap test at 6 months, Houston, validated  
A1. 23.5%  
A2. 24.1%  
A3. 12.3%  
B. 7.2%  
p=0.03 between intervention groups and control group  
p>0.05 among intervention groups  
Pap test at 6 months, Yakima, validated  
A1. 30.0%  
A2. 40.0%  
A3. 37.5%  
B. 6.4%  
p<0.001 between intervention groups and control group  
p>0.05 among intervention groups | Poor  
1. Unclear allocation concealment  
2. No reporting of baseline characteristics, and unclear whether groups were maintained  
3. Unclear masking of outcome assessors, care providers, or patients | Poor  
1. Study population (demographics, inclusion/exclusion criteria, recruitment)  
2. Study setting (system, centers, time, effort)  
3. Study providers (training, expertise, ancillary providers) |
<table>
<thead>
<tr>
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<th>Applicability Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cole et al., 2017</td>
<td>Any type of CRC screening at 6 months</td>
<td>Poor 1. Unclear whether allocation concealment was adequate 2. Outcome assessors were not masked 3. High attrition</td>
<td>Fair 1. Study population (inclusion/exclusion criteria, refusal rate, attrition, recruitment) 2. Study setting (time, effort) 3. Study providers (ancillary providers)</td>
</tr>
</tbody>
</table>
|                                               | A1. 17.5%  
A2. 17.8%  
B. 8.4% | | |
|                                               | Receipt of screening vs. group B, AOR (95% CI)  
A1. 2.28 (1.28 to 4.06)  
A2. 2.44 (1.38 to 4.34) | | |
|                                               | Per protocol analysis, likelihood of CRC screening among those completing patient navigation  
AOR: 16.04 (8.32 to 30.93) | | |
| Coronado et al., 2011                         | FOBT screening:  
A1. 31%  
A2. 26%  
B. 2% | Fair 1. Unclear allocation concealment 2. Unclear masking of outcome assessors, providers, patients | Fair 1. Study providers (training, ancillary providers) 2. Study setting (time, effort) |
|                                               | A1 vs. B: p<0.001  
A2 vs. B: p<0.001  
A1 vs. A2: p=0.28 | | |
| Coronado et al., 2016                         | % of women who received a mammogram in the 12 months after randomization:  
A. 19.6%  
B. 11%, p<0.01 | Fair 1. Unequal demographic groups at baseline 2. ITT- comparable groups not assessed. | Fair 1. Study providers (training, ancillary providers) 2. Intervention (resources) |
|                                               | | | |
| Coronado et al., 2018                         | FIT completion in 12 months:  
A. 13.9%  
B. 10.4%  
Adjusted MD: 3.4 (95% CI 0.1 to 6.8), p=0.05 | Poor 1. Randomization not reported. 2. Allocation concealment unclear. 3. Unclear whether study maintained comparable groups. 4. Unclear whether ITT analysis performed. | Fair 1. Intervention is resource intensive - may not be plausible in all systems. |
|                                               | Any CRC screening (FIT, COL/FS) in 18 months:  
A. 18.3%  
B. 14.5%  
Adjusted MD: 3.8 (95% CI 0.6 to 7.0), p=0.02 | | |
<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
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<tbody>
<tr>
<td>Davis et al., 2013</td>
<td>FOBT completion in 12 months:</td>
<td>Poor</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>A1. 60.6%</td>
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<td>A2. 57.1%</td>
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<td>B. 38.6%, p&lt;0.0001</td>
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<td></td>
<td>Adjusted screening ratio, (95% CI)</td>
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<td></td>
<td>A1 vs. B: 1.60, (1.06 to 2.42), p=0.02</td>
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<td></td>
<td>A1 vs. A2: 1.18 (0.97 to 1.42), p=0.09</td>
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<td>A2 vs. B: 1.36 (0.85 to 2.18), p=0.20</td>
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<tr>
<td>DeGroff et al., 2017</td>
<td>Receipt of colonoscopy within 6 months</td>
<td>Fair</td>
<td>Fair</td>
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<tr>
<td></td>
<td>A. 61.1%</td>
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<tr>
<td></td>
<td>B. 53.2%</td>
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<tr>
<td></td>
<td>p=0.021</td>
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<tr>
<td></td>
<td>OR (95% CI): 1.51 (1.12 to 2.03), p=0.007</td>
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<td>Hispanics vs. Whites, receipt of screening: OR 2.60 95% CI (1.64 to 4.13), p&lt;0.001</td>
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<tr>
<td>Dietrich et al., 2006</td>
<td>A vs. B</td>
<td>Fair</td>
<td>Fair</td>
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<td></td>
<td>Mammogram (% change from baseline): 10% vs. -2%</td>
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<td>Papanicolaou test (% change from baseline): 7% vs. 0%</td>
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<td></td>
<td>Any colorectal screening (% change from baseline): 24% vs. 11%</td>
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<td>Up to date 1+ screening (% change from baseline): 5% vs. 1%</td>
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<td>Up to date 2+ screening (% change from baseline): 14% vs. 1%</td>
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<td>Up to date 3+ screening (% change from baseline): 22% vs. 8%</td>
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<tr>
<td>Dietrich et al., 2013</td>
<td>A vs. B</td>
<td>Fair</td>
<td>Good</td>
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<td></td>
<td>Any CRC screening at 18 months (FOBT, COL/FS, barium enema): 36.7% vs. 30.6%</td>
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<td>AOR (95% CI): 1.32 (1.08 to 1.62), p&lt;0.01</td>
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<tr>
<td>Dignan et al., 2014</td>
<td>Change in screening rates from baseline to 6 months</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td>FOBT results documented: 1.0% vs. 2.9% (p=0.4631)</td>
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<td>Colonoscopy results documented: 5.0% vs. 0.5% (p=0.0969)</td>
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<td></td>
<td>Any screening results documented: 2.2% vs. 0.2% (p=0.7438)</td>
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<td>When limited to those with documented recommendation, changes in screening rates from baseline to 6 months</td>
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<td>Change in colonoscopy: 15.7% vs. 2.4% (p=0.01)</td>
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<td>Change in FOBT: 41.3% vs. 46.2% (p=0.82)</td>
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<td>Any screening completed: 16.7% vs. 9.5% (p=0.06)</td>
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</table>
| Enard et al., 2015 | Colonoscopy, flexible sigmoidoscopy, or FOBT screening rates: A. 43.7%  
B. 32.1%, p=0.04  
AOR: 1.82, p=0.002  
Individually, significant difference only for colonoscopy/flexible sigmoidoscopy, but not FOBT. | Poor  
1. Randomization and allocation concealment NR  
2. Assessor and clinician masking unclear  
3. Differential loss to follow-up  
4. ITT not used. Post randomization exclusions. | Good |
| Fang et al., 2017 | Rate of screening at 12 months after intervention, % (n)  
A. 72.1% (209)  
B. 10.1% (30)  
Among uninsured women  
A. 77.8% (144)  
B. 6.7% (8)  
Rate difference between intervention and control groups, among all women: 62%  
Rate difference between intervention and control groups, among uninsured women: 71.1%  
Intervention led to significantly higher screening rates  
OR, (95% CI): 25.9 (10.1 to 66.1); p<0.001  
In the covariate adjusted model (age, marital status, prior pap receipt, insurance coverage, usual source of care): AOR 35.8; 95% CI (11.1 to 114.9); p<0.001  
Sensitivity analysis: OR 16.7, 95% CI (8.1 to 34.4), p<0.001  
covariate-adjusted analyses: AOR 21.6, 95% CI (9.6 to 49), p<0.001  
Post-hoc analyses to account for the update in screening guidelines that were released that could have impacted women who were not adherent at study entry but due to the update were adherent after study entry. All women who had been screened within the past 3 years were excluded from post-hoc analysis, n=340.  
Obtained screening by followup assessment:  
A. 65.5% (110/168)  
B. 4.7% (8/172)  
OR, (95% CI): 546; (73.9 to 4031.5), p<0.001 | Fair  
1. Differences in groups at baseline | Fair  
1. Exclusive population consisting of only Korean American women |
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</table>
| **Fiscella et al., 2011** | CRC screening  
Unadjusted rates  
A. 28.8% 10.0%  
B. 10.0%  
p=NR  
Adjusted OR: 3.69 (95% CI 1.93 to 7.08)  
Mammography  
Unadjusted rates  
A. 41.0%  
B. 16.8%  
p=NR  
Adjusted OR: 3.44 (95% CI 1.91 to 6.19) | Fair  
1. Inadequate randomization  
2. Allocation concealment not reported  
3. Patient masking, attrition, and contamination not reported | Good |
| **Friedman & Borum, 2007** | Endoscopic procedure  
A: 59.1%  
B: 26.7%  
p<0.001  
Rectal exam  
A: 38.6%  
B: 41.4%  
p=0.6605  
FOBT  
A: 37.9%  
B: 37.7%  
p=0.7748 | NA | Fair  
1. Study setting (Demographics)  
2. Study setting (time, effort)  
3. Study providers (training) |
| **Goldman et al., 2015** | FBOT completed by week, A vs. B  
0 to 2 weeks: 13.8% vs. 2.9%, p≤0.001  
>2 to 13 weeks: 13.8% vs. 4.8%, p=0.001  
FBOT completed month, A vs. B  
6 months: 36.7% vs. 14.8%, p<0.001  
12 months: 40% vs. 22.4, p<0.001  
Total CRC screening, A vs. B  
6 months: 36.7% vs. 15.2%, p<0.001  
12 months: 40% vs. 23.3%, p<0.001 | Fair  
1. method of randomization and allocation concealment NR | Good |
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</table>
| Guillaume et al., 2017b De Mi et al., 2018    | A vs. B  
FOBT within 9 months, overall navigable population: 24.3% vs. 21.1%, p=0.003  
OR, (95% CI): 1.19, (1.10 to 1.29), p<0.001  
FOBT within 9 months, deprived strata: 22.8% vs. 20.2%, p=0.07  
FOBT within 9 months, affluent strata: 26% vs. 21.9%, p=0.001 | Fair 1. Unclear allocation concealment  
2. Groups not comparable at baseline | Fair 1. Study system (background of universal screening and access in France)  
2. Study setting (by geographic strata) |
| Gupta et al., 2013                             | CRC screening at 1 year:  
A1. 24.6%  
A2. 40.7%  
B. 12.1%  
Difference across all groups and between groups: p<0.001  
Number needed to invite (NNI): number of patients needed to be invited to accomplish 1 additional screening  
A1. 8  
A2. 3.5 | Fair 1. Unclear allocation concealment  
2. Unclear loss to followup | Good |
| Hendren et al., 2014                           | CRC screening  
Unadjusted rates  
A. 37.7%  
B. 16.7%  
p=0.0002  
Adjusted OR: 3.22 (95% CI 1.65 to 6.30)  
Mammography  
Unadjusted rates:  
A. 29.7%  
B. 16.7%  
p=0.034  
Adjusted OR: 1.96 (95% CI 0.87 to 4.39)  
Sub-analysis based on race  
Black vs. White vs. Other  
CRC Screening  
Unadjusted rates  
A: 44.19% vs. 34.62% vs. 20.00%  
B: 14.63% vs. 16.13% vs. 30.00%  
Mammography  
Unadjusted rates  
A: 27.03% vs. 25.58% vs. 60.00%  
B: 10.53% vs. 20.51% vs. 33.33% | Fair 1. Care providers not masked, unclear if patients masked, attrition and loss to followup not reported | Good |
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<tbody>
<tr>
<td>Honeycutt et al., 2013</td>
<td>Guideline compliant at study completion (COL in 10 years, FS in 5 years, FOBT in 1 year): A. 42.6% B. 10.8%, p&lt;0.001, effect 5.9, p&lt;0.001 Effect White vs. Black (reference): 1.23, p&gt;0.05</td>
<td>Fair 1. Groups not comparable at baseline 2. Assessors not blinded</td>
<td>Poor 1. Study setting (time, effort) 2. Study provider (ancillary provider)</td>
</tr>
<tr>
<td>Horne et al., 2015</td>
<td>Any CRC screening by exit interview: A. 94% B. 91%, p=0.04 AOR (95% CI) Any CRC screening: 1.56 (1.08 to 2.25), p=0.02 FOBT: 1.09 (0.72 to 1.64), p=0.68 Colonoscopy/sigmoidoscopy: 1.54 (1.08 to 2.20), p=0.02</td>
<td>Fair 1. High attrition 2. Post-randomization exclusions</td>
<td>Fair Unclear what navigation services were offered (or their intensity); trained and certified patient navigator</td>
</tr>
<tr>
<td>Jandorf et al., 2005</td>
<td>FOBT completion at 3 months A. 42.1% B. 25%, p&gt;0.05 Endoscopy completion at 6 months A. 23.7% B. 5%, p=0.02</td>
<td>Poor 1. No information on randomization or allocation 2. No information on masking 3. Unclear on attrition and whether ITT occurred</td>
<td>Good</td>
</tr>
<tr>
<td>Jandorf et al., 2014</td>
<td>Mammography adherence - multivariate analysis - significant increases among women in both groups Baseline to 2-month assessment: OR 2.16; 95% CI 1.69 to 2.76 Baseline to 8 months: OR 8.56; 95% CI 5.85 to 12.53 2 months to 8 months: OR 3.97; 95% CI 2.70 to 5.82 Baseline, 2-month, and 8-month combined, A vs. B: 56.7% vs. 62.2%, p=0.043 Pap adherence - multivariate analysis - significant increases among women in both groups Baseline to 2-month assessment: OR 2.14; 95% CI 1.87 to 2.45 Baseline to 8 months: OR 2.35; 95% CI 2.00 to 2.76 2 months to 8 months: OR 1.78; 95% CI 1.52 to 2. Baseline, 2 month, 8 month combined, A vs. B: 62.7% vs. 64.6%, no difference. Participants of Puerto Rican ethnicity were significantly (OR 1.35; 95% CI 1.09 to 1.67) more likely to be Pap adherent at 2 and 8 months compared to those born in other countries. Significant time by program type interaction (Wald chi-square=6.10; p=0.0472). Baseline: no significant difference in adherence between groups 2-month assessment- women in cancer group were less likely to be adherent: OR 0.74; 95% CI 0.59 to 0.94 8-month assessment- no adherence differences</td>
<td>Fair 1. Allocation concealment not reported. 2. Unclear whether groups were similar at baseline.</td>
<td>Fair 1. Study population (inclusion/exclusion criteria, demographics)</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
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</table>
| **Kim & Sarna, 2004**                        | Screening rate:  
A1: 87% (41/47)  
A2: 72% (35/48)  
A3: 47% (22/46)  
A1 vs. B, OR 1.82 (95% CI 1.32 to 2.51)  
A2 vs. B, OR 1.52 (95% CI 1.08 to 2.16) | Fair  
1. Unclear as to whether outcome assessors were masked  
2. Unclear as to whether attrition or loss to followup occurred | Poor  
1. Study population (inclusion/exclusion criteria, demographics, recruitment)  
2. Study setting (health care system and centers, time)  
3. Study providers (training, expertise or skill, ancillary providers) |
| **Lee-Lin et al., 2015**                      | Mammogram completion  
3 month AOR (95% CI): 8.81 (4.83 to 1605), p<0.001  
6 month AOR (95% CI): 9.10 (3.5 to 23.62), p<0.001  
12 month AOR (95% CI): 4.61 (1.59 to 13.37), p<0.001 | Fair  
1. Poor reporting re: allocation concealment, randomization  
2. Unclear whether ITT was used or post randomization exclusions to synthesis. | Fair  
1. Study providers (training, ancillary providers)  
2. Intervention (resources) |
| **Levy et al., 2013**                         | A1 vs. A2 vs. A3 vs. B  
Any CRC completion: 57.2% vs. 56.5% vs. 20.5% vs. 17.8%, p<0.0001  
AOR (95% CI)  
A1 vs. B: 6.38 (3.9 to 10.5), p<0.0001  
A2 vs. B: 6.29 (3.8 to 10.4), p<0.0001  
A3 vs. B: 1.23 (0.7 to 2.1), p=0.46  
Colonoscopy: 19.3% vs. 22% vs. 17.8% vs. 11.9%, p=0.07  
Unadjusted OR (95% CI)  
A1 vs. B: 1.8 (1.0 to 3.1)  
A2 vs. B: 2.1 (1.2 to 3.7)  
A3 vs. B: 1.6 (0.9 to 2.9)  
FOBT: 1.6% vs. 2.2% vs. 2.7% vs. 2.7%, p=0.875  
Flexible sigmoidoscopy: 0% vs. 0% vs. 0% vs. 0.5%, p=0.389  
Barium enema: 0% for all | Fair  
1. Unclear allocation concealment  
2. Unclear as to whether outcome assessors, providers, patients were masked | Good |
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<tr>
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<tr>
<td>Ma et al., 2009</td>
<td>Baseline colonoscopy, flexible sigmoidoscopy, or FOBT screening rates, A vs. B: 13.1% vs. 9.6% Colonoscopy, flexible sigmoidoscopy, or FOBT screening rates in 12 months following intervention: A. 77.4% B. 10.8% RR (95% CI): 7.14 (3.81 to 13.37) Screening rate following intervention among those who had not had a previous screening within the past year, A vs. B: 76.7% (56/73) vs. 12% (9/75); RR 6.39 (95% CI 3.42 to 11.95)</td>
<td>Poor 1. Inadequate randomization. 2. Allocation concealment not reported. 3. Groups dissimilar at baseline.</td>
<td>Poor 1. Specific population 2. Setting - church based 3. Resource intensive intervention</td>
</tr>
<tr>
<td>Marshall et al., 2016</td>
<td>Self reported mammogram status at exit screening: A. 93.3% B. 87.5%, p&lt;0.001 AOR: 2.26 (95 % CI 1.59 to 3.42; control is reference)</td>
<td>Poor 1. Randomization and concealment not reported. 2. Did not report attrition, crossover, adherence, and contamination.</td>
<td>Fair 1. Specific population 2. Resource intensive intervention</td>
</tr>
<tr>
<td>Mehta et al., 2016</td>
<td>Race/ethnicity and up to date screening, any CRC test, post vs. preprogram, RR (95% CI) A1: 2.05 (2.04 to 2.05) A2: 1.60 (1.59 to 1.60) B: Ref By race/ethnicity, NH White reference, RR (95% CI) NH Black A1: 0.97 (0.96 to 0.97) A2: 0.94 (0.93 to 0.95) B: 1.04 (1.02 to 1.05) Hispanic A1: 0.95 (0.95 to 0.96)* A2: 0.92 (0.92 to 0.93) B: 0.94 (0.93 to 0.96) API A1: 1.02 (1.02 to 1.02) A2: 1.03 (1.02 to 1.03) B: 1.05 (1.04 to 1.06) Native American A1: 0.91 (0.89 to 0.93)* A2: 0.87 (0.84 to 0.90)* B: 0.88 (0.83 to 0.93) Multiple race A1: 1.05 (1.05 to 1.06) A2: 1.07 (1.06 to 1.08) B: 1.11 (1.09 to 1.13) *RR vs. NH Whites in period C not statistically significant at p=0.01</td>
<td>NA</td>
<td>Good</td>
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<tr>
<td>Mehta et al., 2016</td>
<td>Overall, any CRC screening test (age/sex adjusted rates)</td>
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<td>2004: 35.3%</td>
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<td>2013: 80.9%</td>
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<td>NH White, any CRC test</td>
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<td>2004: 35.2%</td>
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<td></td>
<td>2013: 81.1%</td>
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<td>NH Black, any CRC test</td>
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<td>2004: 35.6%</td>
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<tr>
<td></td>
<td>2013: 78.0%</td>
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<td>Hispanic, any CRC test</td>
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<td>2004: 33.1%</td>
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<td>2013: 78.3%</td>
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<td>API, any CRC test</td>
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<td>2004: 36.3%</td>
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<tr>
<td></td>
<td>2013: 83.0%</td>
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<td>Native American, any CRC test</td>
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<td>2004: 29.4%</td>
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<td>2013: 74.5%</td>
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<td>Multiple race, any CRC test</td>
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<td>2004: 39.0%</td>
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<tr>
<td></td>
<td>2013: 84.9%</td>
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<td>(continued)</td>
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<tr>
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| Miller et al., 2013 | Adherence, initial screening  
A1. 75.4%  
A2. 61.8%  
B. 65.6%  
Adherence, 6 months  
A1. 70.0%  
A2. 50.0%  
B. 61.0%  
Adherence, 12 months  
A1. 63.0%  
A2. 58.6%  
B. 53.9%  
*Note A2 and B combined for analysis below for statistical reasons  
Adherence, initial screening  
A1. 75.4%  
A2+B. 63.8%  
p=0.1027  
Adherence, 6 months  
A1. 70.0%  
A2+B: 55.6%  
p=0.1687  
Adherence, 12 months  
A1: 63.0%  
A2+B: 56.4%  
p=0.586  
Total adherence: all three measures favors telephone, p=0.475 | Poor  
1. Allocation concealment unclear  
2. Did not maintain comparable groups  
3. Unclear outcome, provider, patient masking  
4. No ITT analysis  
5. High attrition | Fair  
1. Study population (inclusion/ exclusion criteria, adherence)  
2. Study setting (health care system and center)  
3. Study providers (special training) |
<table>
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<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
</tr>
</thead>
</table>
| Mitchell, Andrews, & Schenker, 2015           | BMI, mean kg/m^2 (95% CI)  
A1. 27.9 (27.1 to 28.1)  
A2. 28.3 (27.9 to 28.8)  
B. 28.6 (28.3 to 28.9)  
p<0.001  
Fruits and veg servings per day, mean (95% CI)  
A1. 6.1 (5.7 to 6.4)  
A2. 5.6 (5.0 to 6.3)  
B. 5.4 (5.0 to 5.8)  
p=0.041  
Nonwork PA for 30 min, days per week, mean (95% CI)  
A1. 3.2 (2.8 to 3.7)  
A2. 2.5 (1.7 to 3.3)  
B. 2.1 (1.6 to 2.6)  
p=0.004 | Poor  
1. Groups not comparable at baseline  
2. High attrition  
3. No ITT analysis | Poor  
1. Study population (demographics, inclusion/exclusion criteria, adherence, recruitment)  
2. Study setting (health care system and center, time, effort)  
3. Study providers (training, expertise, ancillary providers) |
| Myers et al., 2014                            | Any screening, 6 months  
A: 38.0%  
B: 23.7%  
AOR, 95% CI: 2.1 (1.5 to 2.9), p=0.001  
Any screening, 12 months  
A: 43.4%  
B: 32.2%  
AOR, 95% CI: 1.7 (1.2 to 2.3), p=0.001  
Group A, as treated analysis, adherence at 6 months  
Navigated: 45.7%  
Not navigated: 12.4%  
Group A, as treated analysis, adherence at 12 months  
Navigated: 50.9%  
Not navigated: 19.1% | Fair  
1. Unclear if baseline differences exist  
2. Missing data | Fair  
1. Study population (demographics)  
2. Study setting (time, effort)  
3. Study providers (training, ancillary providers) |
<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Outcomes</th>
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<th>Applicability Rating</th>
</tr>
</thead>
</table>
| Nash et al., 2006 | Patient navigation in screening colonoscopy: yes  
A: 45%  
B: 10%  
p<0.001  
Broken appointment  
A: 5.3%  
B: 67.2%  
Likelihood of keeping appointment, RR (95% CI): 2.6 (2.2 to 3.0)  
Average number screening colonoscopies per month  
A: 119.0  
B: 56.8  
By race/ethnicity  
NH Black  
A: 6.0 (5%)  
B: 6.5 (11%)  
Hispanic  
A: 88.0 (74%)  
B: 46.8 (82%)  
Other/unknown  
A: 25.0 (21%)  
B: 3.5 (6%) | NA | Fair  
1. Study population (inclusion/exclusion criteria)  
2. Study setting (Selection of centers, cost of service)  
3. Study providers (training, skill, ancillary providers) |
| Nash et al., 2006 (continued) | Estimated coverage of screening colonoscopies by hospital among eligible population in local area (average per month, %)  
A: 65.1 (15.6%)  
B: 21.8 (5.2%)  
By race/ethnicity  
NH Black  
A: 3.9 (2.4%)  
B: 2.8 (1.7%)  
Hispanic  
A: 47.1 (20.1%)  
B: 17.5 (7.5%)  
Other/unknown  
A: 14.1 (104.5%)  
B: 1.5 (11.1%)  
Likelihood of screening colonoscopy at center, RR (95% CI): 3.0 (1.9 to 4.7)  
Average number of persons screened per month increased from 75.7 to 119.0.  
Individuals screened on Medicaid 48.4% vs. 17%  
p<0.001 | (continued) | (continued) |
<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Outcomes</th>
<th>Quality Rating</th>
<th>Applicability Rating</th>
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<tbody>
<tr>
<td>Navarro et al., 1998</td>
<td>Increase in screening, A vs. B Mammography: 21.4% vs. 7%, p=0.29 Cervical: 23.1% vs. 16.2%, p=0.96</td>
<td>Poor 1. Randomization and allocation concealment unclear 2. Unclear whether comparable groups were maintained 3. Outcome assessor, care provider, and patient masking unclear 4. No ITT analysis 5. Unclear whether post-randomization exclusions occurred</td>
<td>Fair 1. Study population (inclusion/exclusion criteria, demographics, recruitment) 2. Study providers (training, expertise)</td>
</tr>
<tr>
<td>Nguyen et al., 2015</td>
<td>Report of colonoscopy, flexible sigmoidoscopy, or FOBT screening at 6 months, A vs. B 56% vs. 19%, p&lt;0.001 AOR: 5.45; 95% CI 3.02 to 9.82 Intervention was effective in both men and women; no difference by gender.</td>
<td>Poor 1. Randomization and allocation concealment unclear 2. Outcome assessor and patient not masked 3. No ITT analysis 4. Unclear whether post-randomization exclusions occurred 5. Potential for contamination / cross-over</td>
<td>Poor 1. Population - single city, specific racial and ethnic group 2. Special skills - language 3. Effort - training time, special materials</td>
</tr>
<tr>
<td>Percac-Lima et al., 2009</td>
<td>A vs. B CRC screening completion (COL/FS, barium enema, FOBT): 27.4% vs. 11.9%, p&lt;0.001 Colonoscopy: 20.8% vs. 9.6%, p&lt;0.001</td>
<td>Poor 1. Randomization and allocation concealment unclear 2. Unclear whether outcome assessor or patients were masked</td>
<td>Fair 1. Study providers (training, ancillary provider) 2. Study setting (time, effort)</td>
</tr>
<tr>
<td>Percac-Lima et al., 2012</td>
<td>A vs. B Women up to date with mammography: 67.0% (61/91) vs. 44.0% (40/91), p=0.001</td>
<td>NA</td>
<td>Poor 1. Study population is very specific 2. Study setting is in a single clinic</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Outcomes</td>
<td>Quality Rating</td>
<td>Applicability Rating</td>
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<tr>
<td><strong>Percac-Lima et al., 2014</strong></td>
<td>Up to date on screening (colonoscopy, sigmoidoscopy, colonography, or barium enema) before intervention&lt;br&gt;Latinos: 47.5%&lt;br&gt;Non-Latino: 50.4%, p&gt;0.05&lt;br&gt;Up to date on CRC screening after intervention&lt;br&gt;Latinos: 73.5%&lt;br&gt;Non-Latino: 66%&lt;br&gt;p&lt;0.001&lt;br&gt;Non-English speaker: 70.6%&lt;br&gt;English speaker: 68%&lt;br&gt;p=0.09</td>
<td>NA</td>
<td>Fair&lt;br&gt;1. Study population (demographics)&lt;br&gt;2. Study setting (health care system, center, time)&lt;br&gt;3. Study providers (training, skill, ancillary providers)</td>
</tr>
<tr>
<td><strong>Phillips et al., 2011</strong></td>
<td>Adherence, post intervention&lt;br&gt;A: 87%&lt;br&gt;B: 76%&lt;br&gt;AOR (95% CI): 2.5 (1.9 to 3.2)</td>
<td>Fair&lt;br&gt;1. Groups not similar at baseline&lt;br&gt;2. Unclear masking of outcome assessors or analysts&lt;br&gt;3. High attrition/ loss to followup</td>
<td>Fair&lt;br&gt;1. (Study population (inclusion/ exclusion criteria, adherence)&lt;br&gt;2. Study setting (health care system and centers, time)&lt;br&gt;3. Study providers (training, expertise or skill, ancillary providers)</td>
</tr>
<tr>
<td><strong>Powell et al., 2005</strong></td>
<td>A1 vs. A2 vs. B&lt;br&gt;Up-to-date mammography at baseline: 45% vs. 65% vs. 57%&lt;br&gt;Screening received at 3 months: 63% vs. 70% vs. 61%&lt;br&gt;% change from baseline: 38.4% vs. 8.6% vs. 8.1%&lt;br&gt;A1 vs. B: p&lt;0.001&lt;br&gt;A1 vs. A2: p&lt;0.001&lt;br&gt;A2 vs. B: NS</td>
<td>Fair&lt;br&gt;1. Unclear as to whether outcome assessors were masked&lt;br&gt;2. Unclear as to whether attrition or loss to followup occurred</td>
<td>Poor&lt;br&gt;1. Study population (inclusion/ exclusion criteria, demographics, recruitment)&lt;br&gt;2. Study setting (health care system and centers, time)&lt;br&gt;3. Study providers (training, expertise or skill, ancillary providers)</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Outcomes</td>
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<td>Applicability Rating</td>
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</table>
| Reuland et al., 2017 | Any CRC screening at 6 months: 68% vs. 27%, p=NR  
Adjusted difference 40 percentage points, 95% CI 29 to 51 percentage points; number needed to offer intervention to screen 1 additional patient, 3  
FOBT/FIT screening at 6 months: 54% vs. 21%, p=NR  
Colonoscopy screening at 6 months: 14% vs. 6%, p=NR | Good | Good |
| Roetzheim et al., 2004 and 2005 | 12 months  
Intervention increased all screenings:  
Cervical: OR 1.57, 95% CI (0.92 to 2.64), p=0.96  
Breast: OR 1.62, 95% CI (1.07 to 9.78), p=0.23  
CRC (FOBT): OR 2.56, 95% CI (1.65 to 4.01), p<0.001 | Fair  
1. No information regarding randomization/allocation | Fair  
1. Study population (inclusion/exclusion criteria)  
2. Study setting (system, effort) |
| Rosas et al., 2015 | A1 vs. A2 vs. B  
Mean change in BMI at 6 months, kg/m2, (95% CI): -0.8 (-1.1 to -0.5) vs. -0.6 (-1.0 to -0.3) vs. -0.4 (-0.7 to 0), p>0.05 for all comparisons  
Mean change in BMI at 12 months, kg/m2, (95% CI): -0.7 (-1.1 to -0.3) vs. -0.6 (-1.0 to -0.1) vs. -0.3 (-0.8 to 0.3), p>0.05 for all comparisons  
Mean change in BMI at 24 months, kg/m2, (95% CI): -0.4 (-0.9 to 0.2) vs. -0.4 (-1.0 to 0.2) vs. -0.2 (-1.1 to 0.7), p>0.05 for all comparisons  
Mean change in weight at 6 months (95% CI): -2.1 kg (-2.8 to -1.3) vs. -1.6 kg (-2.4 to -0.7) vs. -0.9 kg (-1.9 to 1.1), p=0.05 (A), p>0.05 (B) vs. C; p>0.05 A vs. B  
mean change in weight at 12 months (95% CI): -1.9 kg (-2.9 to -0.9) vs. -1.4 kg (-2.4 to 0.3) vs. -0.7 kg (-2.2 to 0.8), p>0.05 for all comparisons  
Mean change in weight at 24 months (95% CI): -1.0 kg (-2.4 to 0.4) vs. -1.0 kg (-2.4 to 1.0) vs. -0.6 kg (-2.8 to 1.5), p>0.05 for all comparisons | Good | Poor  
1. Study population (inclusion/exclusion, demographics, absolute risk)  
2. Study setting (center, time, effort)  
3. Study provider (training, expertise/skill, ancillary provider) |
<table>
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</thead>
<tbody>
<tr>
<td>Singal et al., 2016</td>
<td>A1 vs. A2 vs. B Completion within 12 months of any test: 42.4% vs. 58.8% vs. 29.6% A1 vs. B: p=0.0001 A2 vs. B: p=0.0001 A2 vs. A1: p&lt;0.001 AOR (95% CI) A1 vs. B: 1.83 (1.57 to 2.14) A2 vs. B: 3.84 (3.28 to 4.5)</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Staten et al., 2004 Arizona WISEWOMAN</td>
<td>A1 vs. A2 vs. B Change in BMI from baseline to 12 months (95% CI): 0.1 (-0.3 to 0.6) vs. 0.7 (-0.1 to 1.4) vs. -0.1 (-0.6 to 0.5), p=NR Change in % of study arm at BMI ≥25 from baseline to 12 months: -4.6% vs. 4.2% vs. 0% Adjusted effect of intervention at 12 months (β, SE, p), A1 vs. B: 0.28, 0.45, p=0.53; A2 vs. B: 0.77, 0.44, p=0.08; A1 vs. A2: -0.49, 0.46, p=0.28</td>
<td>Poor 1. Unclear randomization and allocation concealment 2. Unclear whether maintained comparable groups 3. Unclear masking of outcome assessor, provider, patient 4. No ITT 5. Post-randomization exclusions</td>
<td>Fair 1. Time, effort required for intervention 2. Ancillary providers</td>
</tr>
<tr>
<td>Stoddard et al., 2004 Massachusetts WISEWOMAN</td>
<td>A vs. B High blood pressure, excluding women on medication at baseline, adjusted difference (baseline to 12 months): -6.8 (33.8 to 27, p=0.02) vs. -8.6 (31.5 to 22.9, p&lt;0.01); p=0.51</td>
<td>Poor 1. Unclear randomization and allocation concealment 2. Unclear whether maintained comparable groups 3. Unclear masking of outcome assessor, provider, patient 4. No ITT 5. Unclear whether one site was excluded pre- or post-randomization</td>
<td>Fair 1. Time, effort required for intervention 2. Ancillary providers</td>
</tr>
<tr>
<td>Taplin et al., 2008</td>
<td>A vs. B Breast: 39% vs. 23.2%, p&lt;0.001 Cervical: 37.2% vs. 25.2% p&lt;0.001 Colorectal: 21.2% vs. 8.6%, p&lt;0.001</td>
<td>NA</td>
<td>Poor 1. Intervention - intervention that includes the community and many others that provide barriers to implementation.</td>
</tr>
<tr>
<td>Author, Year (See Appendix B for full citation)</td>
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<tr>
<td>Tu et al., 2006</td>
<td>A vs. B</td>
<td>FOBT completion at 6 months: 69.5% vs. 27.6% AOR (95% CI): 6.38 (3.44 to 11.85), p=NR</td>
<td>Poor 1. Unclear allocation concealment 2. Unclear maintaining comparable groups 3. Unclear masking of outcome assessor, provider, patient 4. No ITT</td>
</tr>
<tr>
<td>Weber &amp; Reilly, 1997</td>
<td>A vs. B</td>
<td>Mammogram (ITT): 25% vs. 9.8% RR (95% CI): 2.57 (1.53 to 4.35), p&lt;0.001 Mammogram (per protocol): 29% vs. 11% RR (95% CI): 2.67 (1.59 to 4.48), p&lt;0.001 Mammogram (“truly eligible”, p. 2347): 41% vs. 14% RR (95% CI): 2.87 (1.75 to 4.73), p&lt;0.001</td>
<td>Poor 1. Randomization and allocation concealment techniques not reported 2. Unclear allocation and masking</td>
</tr>
<tr>
<td>West et al., 2004</td>
<td>Receipt of mammogram, Stage 1</td>
<td>A1: 14% B1: 14% Receipt of mammogram, Stage 2</td>
<td>Fair 1. Unclear masking outcome or analysts 2. High differential loss to followup (12.2%) in Stage 1, but not Stage 2 or overall</td>
</tr>
<tr>
<td></td>
<td>Receipt of mammogram among women with no prior mammography, Stage 2</td>
<td>A2: 15% B2: 13%</td>
<td></td>
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<tr>
<td>Wu &amp; Lin, 2015</td>
<td>Obtained screening at followup, A vs. B:</td>
<td>Total: 40% vs. 33%, p=NS Women with insurance: 56% vs. 34%, p=0.03 Women &gt;65 years: 51% vs. 25%, p=NS</td>
<td>Poor 1. Randomization and allocation concealment unclear 2. Unclear whether outcome, provider, patient were masked 3. Differential and overall loss to followup 4. Post-randomization exclusions 5. No ITT analysis</td>
</tr>
</tbody>
</table>

**Abbreviations:** AOR = adjusted odds ratio; API = Asian-Pacific Islander; BMI = body mass index; CI = confidence interval; COL = colonoscopy; COL/FS = colonoscopy/flexible sigmoidoscopy; CRC = colorectal cancer; FIT = fecal immunochemical test; FOBT = fecal occult blood test; FS = flexible sigmoidoscopy; ITT = intention-to-treat; kg = kilogram; kg/m² = kilogram per meters squared; MD = maximum difference; NA = not applicable; NH = non-Hispanic; NNI = number needed to invite; NNT = number needed to treat; NR = not reported; NS = not significant; OR = odds ratio; PA = physical activity; Pap = Papanicolaou test; RR = relative risk; US = United States; WISEWOMAN = Well-Integrated Screening and Evaluation for WOMen Across the Nation

See Appendix B. Included Studies for full citations
## Appendix G. Quality Assessment

### Table G-1. Quality assessment of randomized controlled trials

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<tr>
<td>Abood, 2005</td>
<td>No</td>
<td>NA</td>
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<td>No</td>
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<tr>
<td>Allen, 2005</td>
<td>Yes</td>
<td>NR</td>
<td>No</td>
<td>Yes</td>
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<td>Arnold, 2016a and 2016b</td>
<td>Yes</td>
<td>NR</td>
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<td>Ahmed, 2010</td>
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<td>Bastani, 2015</td>
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<td>Blumenthal, 2010</td>
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<td>Braun, 2015</td>
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<td>Byrd, 2013</td>
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<td>Christie, 2008</td>
<td>NR</td>
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<td>Cole, 2017</td>
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<td>Yes</td>
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<td>Coronado, 2018</td>
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<td>DeGroff, 2017</td>
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<td>Fang, 2017</td>
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<td>Fiscella, 2011</td>
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<td>Guillaume, 2017b</td>
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Abbreviations: NA = not applicable; NR = not reported

See Appendix B. Included Studies for full citations
Table G-2. Quality assessment of randomized controlled trials (continued)

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<td>Reiter Affiliated Companies; Oxnard, California; Western Center for Agricultural Health and Safety</td>
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<td>Muller, 2017</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>National Cancer Institute</td>
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<td>Myers, 2014</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>American Cancer Society</td>
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<td>Navarro, 1998</td>
<td>Yes</td>
<td>Yes</td>
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<td>Nguyen, 2015</td>
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<td>Percac-Lima, 2009</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Massachusetts General primary Care Practice-Based Research network, Massachusetts Cancer Prevention Community Research Network, multiple local grants and awards</td>
<td>Fair</td>
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<td>Phillips, 2011</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Avon Foundation Safety Net Grant</td>
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<td>Powell, 2005</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Grants from Centers for Medicare and Medicaid</td>
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<td>Reuland, 2017</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>America Cancer Society; Agency for Healthcare Research and Quality; National Institutes of Health</td>
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<td>Richter, 2015</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>National Heart, Lung, and Blood Institute</td>
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<td>Roetzheim, 2004, 2005</td>
<td>Yes</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
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<td>National Cancer Institute</td>
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<td>Rosas, 2015</td>
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<td>Siddiqui, 2011</td>
<td>No</td>
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<td>Simon, 2001</td>
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<td>Singal, 2016</td>
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<td>Yes</td>
<td>NCI, NIH, AHRQ</td>
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<tr>
<td>Author, Year (See Appendix B for full citation)</td>
<td>Reporting of attrition, crossovers, adherence, and contamination?</td>
<td>Loss to followup: differential/ high?</td>
<td>Intention-to-treat analysis?</td>
<td>Post-randomization exclusions?</td>
<td>Outcomes Pre-specified</td>
<td>Funding Source</td>
<td>Applicability</td>
<td>Quality Rating</td>
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<td>Staten, 2014</td>
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<td>Yes</td>
<td>CDC</td>
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<td>Stoddard, 2004</td>
<td>Yes</td>
<td>No</td>
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<td>Yes</td>
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<td>Studts, 2012</td>
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<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<td>Thompson, 2017</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>National Institutes of Health to the Fred Hutchinson Cancer Research Center; National Center for Research Resources/National Institute of Health</td>
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<td>Tu, 2006</td>
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<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
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<td>Valdez, 2018</td>
<td>No</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>Yes</td>
<td>National Cancer Institute</td>
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<td>Weber, 1997</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>New York State Department of Public Health Primary Care Initiative</td>
<td>Fair</td>
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<td>West 2004</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Grants from National Cancer Institute-National Institutes of Health &amp; University of Alabama at Birmingham Center for Health Promotion</td>
<td>Fair</td>
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<td>Wu, 2015</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>National Cancer Institute, National Institutes of Health</td>
<td>Fair</td>
<td>Poor</td>
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**Abbreviations:** NA = not applicable; NR = not reported

See Appendix B. Included Studies for full citations
Table G-3. Risk of bias: cohort studies

<table>
<thead>
<tr>
<th>Author, Year (See Appendix B for full citation)</th>
<th>Did the study attempt to enroll a random sample or consecutive patients meeting inclusion criteria (inception cohort)?</th>
<th>Were the groups comparable at baseline?</th>
<th>Did the study use accurate methods for ascertaining exposures, potential confounders, and outcomes?</th>
<th>Were outcome assessors and/or data analysts blinded to treatment?</th>
<th>Did the article report attrition?</th>
<th>Did the study perform appropriate statistical analyses on potential confounders?</th>
<th>Is there important differential loss to followup or overall high loss to followup?</th>
<th>Were outcomes pre-specified and defined, and ascertained using accurate methods?</th>
<th>Applicability</th>
<th>Quality</th>
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<tbody>
<tr>
<td>Battaglia, 2012</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Unclear</td>
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<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Fair</td>
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<td>Davis, 2013</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Unclear</td>
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<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<td>Poor</td>
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<tr>
<td>Guillaume, 2017a</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>Yes</td>
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<td>Honeycutt, 2013</td>
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<td>Yes</td>
<td>Unclear</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Poor</td>
<td>Fair</td>
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<td>Wang, 2010</td>
<td>No</td>
<td>No</td>
<td>Unclear</td>
<td>Unclear</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Good</td>
<td>Poor</td>
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</table>

Abbreviations: NA = not applicable; NR = not reported

See Appendix B. Included Studies for full citations
### Appendix H. Community-based Studies

#### Table H-1. Community-based studies: study characteristics

<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Preventive Service</th>
<th>Disparity Population</th>
<th>Study Design (N)</th>
<th>Population; Age (mean; range); Gender; Race</th>
<th>Setting</th>
<th>Interventions/Study Objective</th>
<th>Comparison</th>
<th>Duration; Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carlini et al., 2012</td>
<td>Tobacco cessation</td>
<td>Low-income (Medicaid and uninsured)</td>
<td>RCT (521)</td>
<td>Age, mean: 42.6 years Female: 64.1% Race White: 81.6% African American: 5.8 % Latino/Hispanic: 3.9% Native American/Pacific Islander: 3.3% Asian: 0.9% Other: 4.6% Insurance status Medicaid: 56.2% No Insurance: 43.8%</td>
<td>General community (Medicaid recipients enrolled in quitlines in Indiana and Washington between June and September 2009), Indiana and Washington</td>
<td>Interactive voice response (IVR) system to recycle smokers who used a quitline in the past back into quitline support for a new quit attempt</td>
<td>A: Control group (n=276) B: IVR intervention group (n=245)</td>
<td>Duration: 6 weeks Followup: up to 1 month after last attempt of reaching participants (10 weeks total)</td>
</tr>
<tr>
<td>Dunlop et al., 2016</td>
<td>Cervical cancer screening</td>
<td>Low income</td>
<td>Before-After Georgia Title X and Medicare data (172,525)</td>
<td>Age: NR 18 to 44 eligible Female: 100% Race: NR</td>
<td>Georgia</td>
<td>CMS Georgia Planning for Healthy Babies (P4HB) Program. Expanded family planning services to uninsured women 18 to 44 at or below 200% Federal Poverty Line. Included a cervical cytology testing.</td>
<td>Pre-post: 2 years pre, 3 years post.</td>
<td>3 years post</td>
</tr>
<tr>
<td>Harrison et al., 2003</td>
<td>Breast cancer screening</td>
<td>Older Women, African American, Rural/Urban</td>
<td>RCT (2,458)</td>
<td>Age: 78.9 Female: 100% Race Black: 22%</td>
<td>Michigan</td>
<td>A. The intervention consisted of a letter, brochure, and information sheet. Education, addressing barriers. B. Matched-control (matched on zip code and race)</td>
<td></td>
<td>5 years</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
<td>Setting</td>
<td>Interventions/Study Objective</td>
<td>Comparison</td>
<td>Duration; Followup</td>
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</tr>
<tr>
<td>Kandula et al., 2015&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Health behaviors for CVD (PA, nutrition, tobacco cessation)</td>
<td>Race - South Asians</td>
<td>RCT (63)</td>
<td>Medically underserved South Asian immigrants at risk for ASCVD Age, year (SD) A: 50 (8) B: 50 (7) Male, % A: 35% B: 38%</td>
<td>Metropolitan Asian Family Services - a not-for-profit community-based organization that provides social services in Illinois</td>
<td>A. South Asian Heart Lifestyle Intervention - integrates evidence-based behavior change strategies with South Asians’ sociocultural context and beliefs (31) B. Given preexisting print education materials about ASCVD, diet, exercise, and weight loss (32)</td>
<td></td>
<td>October 2012 to July 2013; 3 and 6 months</td>
</tr>
<tr>
<td>Kelaher &amp; Stellman, 2000&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Breast cancer screening</td>
<td>Older women 65 to 69, Medicare eligible</td>
<td>Retrospective cohort: National Health Interview Survey Data (4,291; 2,419 Medicare eligible, 1,872 noneligible)</td>
<td>Age: 65 to 69 Female 100% Race (Among Medicare Eligible): Black 53.4%, Non-Black 53.4%; Hispanic 47.6%, Non-Hispanic 55%</td>
<td>NR NHIS data</td>
<td>Biennial mammography coverage with Medicare Part B. Change in 1991</td>
<td>Noneligible (aged 60 to 64), Pre-intervention</td>
<td>Compared 1990, 1993</td>
</tr>
<tr>
<td>Marino et al., 2016&lt;sup&gt;6&lt;/sup&gt;</td>
<td>Breast, cervical, and colorectal cancer screening; Diabetes; Hypertension; Obesity; Smoking</td>
<td>Medicaid</td>
<td>RCT (10,643)</td>
<td>Age: 39 (11.8) years Female: 55% Race: 60% white, 20% non-Hispanic other, 13% Hispanic, 6% unknown</td>
<td>Oregon community health clinics</td>
<td>Oregon Experiment: a randomized natural experiment of the effect of Medicaid coverage on screening rates</td>
<td>Not assigned to Medicaid</td>
<td>36 months</td>
</tr>
<tr>
<td>Miller &amp; Sedivy, 2009&lt;sup&gt;7&lt;/sup&gt;</td>
<td>Tobacco cessation</td>
<td>Low-income</td>
<td>Observational study (1,377)</td>
<td>*Note: significantly different by smoking behavior at baseline A: Intervention Age, mean: 48.3 years Female: 65.3% Indigenous: 1.1% B: Comparison Age, mean: 49.7 years Female: 62.1% Indigenous: 2.4%</td>
<td>National quitline in Australia</td>
<td>Standard multi-session quitline counseling, mailed vouchers for subsidized NRT</td>
<td>Standard multi-session quitline counseling</td>
<td>No more than 12 weeks of counseling sessions; followup at 3, 6, and 12 months</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
<td>Setting</td>
<td>Interventions/Study Objective</td>
<td>Comparison</td>
<td>Duration; Followup</td>
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<td>O’Brien et al., 2010</td>
<td>Cervical cancer screening</td>
<td>Race- Hispanic women</td>
<td>RCT (120)</td>
<td>Hispanic women Age (SD) A. 32 (11) B. 31 (12), p=0.49</td>
<td>Community, Pennsylvania</td>
<td>A. Promotora-led cervical cancer intervention: two 3-hour workshops (60)</td>
<td>B. Usual care (60)</td>
<td>4 months; 6 months</td>
</tr>
<tr>
<td>Plescia et al., 2008</td>
<td>Health behaviors for CVD (PA, nutrition, tobacco cessation)</td>
<td>African American</td>
<td>Quasi-experimental</td>
<td>A: Intervention Age 18 to 34: 20.2% 35 to 44: 17.3% 45 to 54: 19.6% 55 to 64: 16.2% 65+: 26.0% Female: 63.4% B: Comparison Age 18 to 34: 33.1% 35 to 44: 20.9% 45 to 54: 19.0% 55 to 64: 11.8% 65+: 14.4% Female: 55.8%</td>
<td>Community (NW corridor of Charlotte, NC), including health center</td>
<td>Community coalition, lay health advisors, policy and community change</td>
<td>African-American respondents to BRFSS in North Carolina during study period</td>
<td>5 years; annual telephone surveys</td>
</tr>
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<td>Richards et al., 2011</td>
<td>Colorectal cancer screening</td>
<td>Age, SES</td>
<td>Before-After/Cross-sectional N 2003: 826,163 2007: 1,252,313</td>
<td>NR</td>
<td>City-wide campaign New York</td>
<td>Multihealth marketing campaign targeting low SES areas and &quot;ethnic radio stations.&quot; Patient navigation programs, improved referral processes, etc.</td>
<td>Pre-post/Cross-sectional</td>
<td>4 years</td>
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<tr>
<td>Sung et al., 1997</td>
<td>Cervical and breast cancer screening</td>
<td>Low-income, African-American women</td>
<td>RCT (321)</td>
<td>Low-income, inner-city African-American women Mean age (range): NR Age % (n) &gt;35: 13.4 (43) 35 to 44: 45.2 (145) 45 to 59: 23.3 (75) 60 and older: 18.1 (58) Female: 100% African American: 100%</td>
<td>In-home Georgia</td>
<td>A. In-home culturally sensitive educational program with lay health workers. Consists of two educational sessions and a third review session. Materials included videotape and culturally appropriate printed materials (n=163)</td>
<td>B. Control (n=158) Interviewed at the end of the study, received educational materials on cancer screening after the intervention period (at followup)</td>
<td>Duration: 11 months Followup: 6 months</td>
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<tr>
<td>Author, Year</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
<td>Setting</td>
<td>Interventions/Study Objective</td>
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<td>Sung et al., 1997 (continued)</td>
<td>Cervical and breast cancer screening</td>
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<td>Van Der Wees et al., 2013</td>
<td>Breast, cervical, colorectal cancer screening</td>
<td>SES</td>
<td>Before-After (345, 211)</td>
<td>NR</td>
<td>State-wide Massachusetts</td>
<td>Subsidized health insurance in MA (2006 Health Reform)</td>
<td>Pre-post/other NE states</td>
<td>10 years</td>
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<td>Williams et al., 2016</td>
<td>Health behaviors for CVD (PA, nutrition, tobacco cessation)</td>
<td>African American</td>
<td>Before-After (201)</td>
<td>Age, mean (SD): 51.9 years (12.8) Age, median (IQR): 54 years (17) Female: 73.6</td>
<td>Baptist churches Alabama</td>
<td>NHLBI-based curriculum tailored for delivery by CHWs to African Americans; six 2-hour education sessions on CVD risk reduction including handouts, individual goal setting</td>
<td>Baseline</td>
<td>3 months; followup within 1 week of study completion</td>
</tr>
<tr>
<td>Author, Year</td>
<td>Preventive Service</td>
<td>Disparity Population</td>
<td>Study Design (N)</td>
<td>Population; Age (mean; range); Gender; Race</td>
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<tr>
<td>Zhou et al., 2014&lt;sup&gt;14&lt;/sup&gt;</td>
<td>Tobacco cessation</td>
<td>Asian American</td>
<td>Community change (14,540)</td>
<td>A: Intervention Vietnamese men Age 18 to 34: 28.3% 35 to 44: 26.6% 45 to 54: 19.6% 55 to 64: 12.7% 65+: 12.8%</td>
<td>Community and systems changes California and Massachusetts</td>
<td>Cultural- and language-appropriate health communications via radio, cable TV, printed materials; community and systems change; education and promotion via trained lay health workers</td>
<td>State population (men)</td>
<td>Followup annually 2002 to 2006</td>
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<td></td>
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<td></td>
<td>Average Vietnamese men per year: 904 Age</td>
<td>B: Control Vietnamese men California Age 18 to 34: 36.4% 35 to 44: 22.1% 45 to 54: 18.1% 55 to 64: 11.1% 65+: 12.3%</td>
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<td>Average Cambodian men per year: 334 Age</td>
<td>C: Intervention Cambodian men Age 18 to 34: 39.9% 35 to 44: 32.1% 45 to 54: 16.1% 55 to 64: 4.6% 65+: 7.3%</td>
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<td>D: Control Cambodian men Massachusetts Age 18 to 34: 32.2% 35 to 44: 22.1% 45 to 54: 18.7% 55 to 64: 12.3% 65+: 14.8%</td>
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<tr>
<td>Zhu et al., 2012</td>
<td>Tobacco cessation</td>
<td>Asian American</td>
<td>RCT (2,277) A: Intervention 1,124 B: Control 1,153</td>
<td>A: Intervention Age 18 to 24: 3.3% 25 to 44: 45.8% 45 to 64: 45.1% 65+: 5.8% Female: 10% Language Chinese: 31.9% Korean: 37.6% Vietnamese: 30.5% B: Control Age 18 to 24: 3.0% 25 to 44: 44.0% 45 to 64: 44.9% 65+: 8.1% Female: 10% Language Chinese: 32.1% Korean: 36.9% Vietnamese: 31.0%</td>
<td>Telephone quitline California</td>
<td>A. Toll-free Asian-language tobacco quitline promoted in CA, CO, HI, NY, TX, WA from January 2010 to July 2012, offering six telephone counseling sessions and self-help materials, plus free nicotine patches where available</td>
<td>B. Self-help materials</td>
<td>Up to six calls over one month (pre-quit, 3, 7, 14, 30 days post quitting), evaluation 4 and 7 months postintake</td>
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<td>Author, Year</td>
<td>Outcomes</td>
<td>Quality Rating</td>
<td>Applicability Rating</td>
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</table>
| Carlini et al., 2012<sup>1</sup> | Quitline re-enrollment rate  
A: 3.3% (9/276)  
B: 28.2% (69/245)  
OR 11.2 (95% CI 5.4 to 23.3), p<0.001 | Poor  
1. Randomization, allocation concealment, masking of outcome assessors not described,  
2. ITT analysis unclear  
3. Large proportion of attrition | Good |
| Dunlop et al., 2016<sup>2</sup> | Significantly more women screened during visit (p<0.001) in postintervention years. | NA | Good |
| Harrison et al., 2003<sup>3</sup> | Mammography rates during 14 month postintervention period, A vs. B  
Total sample: 5.2% vs. 8.1%, OR 1.6, 95% CI 1.15 to 2.21, p≤0.01  
Urban Black: 4.9% vs. 9.2%, OR 2.09, 95% CI 1.04 to 4.22, p≤0.05  
Rural Non-Black: 6.7% vs. 9.2%, OR 1.44, 95% CI 0.76 to 2.52, NS  
Age 70 to 79: 6.5% vs. 10.6, OR 1.71, 95% CI 1.16 to 2.52, p≤0.01  
Age 80+: 3.6% vs. 4.6%, OR 1.29, 95% CI 0.69 to 2.39, NS | Good | Good |
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<th>Author, Year</th>
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<tr>
<td>Kandula et al., 2015¹</td>
<td>Mean (95% CI)</td>
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<td></td>
<td>Change in bout-corrected moderate-vigorous physical activity, min/week</td>
<td>Good</td>
<td>Only occurred in one community center, unclear whether it is applicable in other communities.</td>
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<td></td>
<td>3 months</td>
<td></td>
<td>2. Seems resource heavy.</td>
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<td></td>
<td>A. 15.5 (−13.06 to 44.07)</td>
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<td></td>
<td>B. 7.3 (−19.00 to 33.56)</td>
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<td></td>
<td>Adjusted mean difference: 8.2 (−29.23 to 45.68)</td>
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<tr>
<td></td>
<td>6 months</td>
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<tr>
<td></td>
<td>A. 9.5 (−19.49 to 38.53)</td>
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<td></td>
<td>B. 4.4 (−23.08 to 31.83)</td>
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<td>Adjusted mean difference: 5.1 (−32.98 to 43.26)</td>
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<td></td>
<td>Change in percent kilocalories from saturated fat intake, %</td>
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<td>3 months</td>
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<tr>
<td></td>
<td>A. −0.24 (−1.15 to 0.68)</td>
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<td>B. 0.12 (−0.76 to 1.01)</td>
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<td>Adjusted mean difference: −0.36 (−1.60 to 0.88)</td>
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<td>6 months</td>
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<td></td>
<td>A. 0.37 (−0.64 to 1.39)</td>
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<td>B. 0.58 (−0.42 to 1.59)</td>
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<td>Adjusted mean difference: −0.21 (−1.59 to 1.17)</td>
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<td></td>
<td>Change in energy intake, kcalories/day</td>
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<td>3 months</td>
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<td>A. −182 (303.61 to −59.67)</td>
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<td>B. −52 (−170.92 to 66.60)</td>
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<td>Adjusted mean difference: −129 (−293.40 to 34.44)</td>
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<td>6 months</td>
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<td>A. −173 (−290.33 to −55.75)</td>
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<td>B. −99 (−214.72 to 16.84)</td>
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<td>Adjusted mean difference: −74 (−223.03 to 74.84)</td>
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<td></td>
<td>Change in fruit and vegetable intake, servings/day</td>
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<td>3 months</td>
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<tr>
<td></td>
<td>A. 0.5 (−0.01 to 1.09)</td>
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<td>B. 0.1 (−0.45 to 0.62)</td>
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<td>Adjusted mean difference: 0.5 (−0.23 to 1.14)</td>
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<td></td>
<td>6 months</td>
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<tr>
<td></td>
<td>A. 0.04 (−.52 to 0.60)</td>
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<td></td>
<td>B. 0.5 (−0.07 to 1.03)</td>
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<td></td>
<td>Adjusted mean difference: −0.4 (−1.15 to 0.26)</td>
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<td>Kelaher &amp; Stellman, 2000&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Predictors of mammogram in last 2 years, by year 1993 vs. 1990 57.3% vs. 50.3%, OR 1.2, 95% CI 0.9 to 1.4, NS  Predictors of mammogram in last 2 years, by Medicare-eligible status 51.9% vs. 54.0%, OR 0.8, 95% CI 0.7 to 1.0, p&lt;0.05 (favors control)  Mammogram in last 2 years, by year of interview 1990 vs. 1993: Medicare eligible: 47.7% vs. 63.3%  Medicare ineligible: 53.3% vs. 60.8% no statistics provided.</td>
<td>Poor 1. No statistical analysis of pre-post Medicare eligible population 2. Self-report data based on national survey</td>
<td>Good</td>
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<td>Marino et al., 2016&lt;sup&gt;6&lt;/sup&gt;</td>
<td>Change, Medicaid coverage vs. unselected BMI: 12.5% (95% CI 10.6 to 14.4)  Blood pressure: 10.1% (95% CI 7.0 to 13.3)  Smoking: 6.2% (95% CI 5.3 to 7.1)  Pap test: 10.3% (95% CI 8.8 to 11.7)  Mammography: 14.5% (95% CI 10.1 to 18.8)  FOBT: -0.2% (95% CI -5.1 to 4.7)  Colonoscopy: 2.7% (95% CI -1.7 to 7.1)  Glucose: 4.8% (95% CI -3.0 to 12.7)  HbA1c: 0.8% (95% CI -4.0 to 5.7)</td>
<td>Fair 1. Unclear whether assessors were blinded. 2. Unclear whether attrition occurred</td>
<td>Fair 1. Study population (demographics, inclusion/exclusion criteria) 2. Study setting (system)</td>
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<tr>
<td>Author, Year</td>
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<tr>
<td>Miller &amp; Sedivy, 2009&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Responder estimates Attempted to quit A: 83.8% B: 74.8% p&lt;0.001 Quit at 3 months A: 46.0% B: 29.5% p&lt;0.001 Quit at 6 months A: 37.1% B: 26.2% p&lt;0.001 Quit at 12 months A: 33.2% B: 28.0% Sustained abstinence from 3 to 6 months followup A: 20.7% B: 13.1% p&lt;0.01 Sustained abstinence, 3 to 12 months followup A: 2.7% B: 2.0% Self-reported NRT use A: 57.9% B: 22.3% p&lt;0.05 Mean days NRT use (SD) A: 38.8 days (26.0) B: 22.2 days (22.0) p&lt;0.05 Number of calls from quitline, mean (SD) A: 6.6 calls (3.7) B: 5.8 calls (3.9) p&lt;0.001</td>
<td>Poor 1. Groups not comparable at baseline, and participants allowed in outside of original purposeful sampling 2. High attrition / loss to followup</td>
<td>Fair 1. Study population (inclusion/ exclusion criteria, refusal rate, adherence, recruitment)</td>
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<td>O'Brien et al., 2010&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Receipt of Pap smear, % (n) A. 65% (22)* B. 36% (13)*</td>
<td>Fair</td>
<td>Fair 1. Difficult to understand the setting in which the intervention occurs. Not sure if it would work in all communities</td>
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<sup>1</sup>Nickel et al., 2010

<sup>2</sup>Miller & Sedivy, 2009

<sup>3</sup>O'Brien et al., 2010

<sup>4</sup>Bateson et al., 2010

<sup>5</sup>Ashton et al., 2010

<sup>6</sup>Bateson et al., 2010

<sup>7</sup>Prior et al., 2010

<sup>8</sup>O'Brien et al., 2010

<sup>9</sup>Ashton et al., 2010

<sup>10</sup>Miller & Sedivy, 2009
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<tbody>
<tr>
<td>Plescia et al., 2008&lt;sup&gt;8&lt;/sup&gt;</td>
<td>Does not meet any PA recommendation, 2001 A: 31.9% (28.3 to 35.7) B: 23.1% (19.3 to 27.5) p&lt;0.001</td>
<td>Fair</td>
<td>Poor</td>
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<td></td>
<td>Does not meet any PA recommendation, 2005 A: 27.4% (24.1 to 30.9) B: 25.5% (23.4 to 27.8)</td>
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<td>Consumes 5+ veg/fruits daily, 2001 A: 23.1% (20.1 to 26.5) B: 21.7% (16.4 to 28.1)</td>
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<td>Consumes 5+ veg/fruits daily, 2005 A: 25.3% (22.2 to 28.7) B: 17.5% (15.7 to 19.4) p&lt;0.001</td>
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<td>Currently smokes, 2001 A: 27.3% (24.0 to 30.8) B: 21.1% (17.6 to 25.1) p=0.02</td>
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<td>Currently smokes, 2005 A: 26.6% (23.3 to 30.2) B: 22.3% (20.2 to 24.7) p=0.04</td>
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<tr>
<td>Richards et al., 2011&lt;sup&gt;10&lt;/sup&gt;</td>
<td>These figures show the elimination of racial/ethnic disparities by 2007 among non-Hispanic Whites, non-Hispanic Blacks, and Hispanics, and highlight persistently lower screening levels among Asians, despite a significant improvement over time, a 29-percentage-point increase. Disparities between the sexes were lessened over time as well: while men had a higher prevalence of screening in 2003, women had a greater percentage-point increase than men (22.3% vs. 16.7%), effectively eliminating the sex disparity. Similarly, disparities between adults with private, Medicaid, and Medicare insurance also disappeared over time, yet those with no insurance continued to lag behind in 2007. In addition, disparities between income levels and education levels persisted. Adults with high household incomes—600% of the federal poverty level or more—continued to have a much higher prevalence of timely colonoscopy screening than all other income groups. Those with at least some college education were more likely to be screened throughout 2003 to 2007 than those with a high school degree or less. In 2003, those aged 50 to 64 were less likely to have been screened than those 65 and older, and this difference by age group persisted into 2007.</td>
<td>NA</td>
<td>Fair</td>
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<td>1. Population: NY urban population, not applicable to other locations 2. Intervention: city-wide intervention</td>
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<tr>
<td>Sung et al., 1997</td>
<td>Obtained cancer screening exam on recommended schedule, whole sample size</td>
<td>Fair</td>
<td>Fair</td>
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<td></td>
<td>Pap smear, % (n)</td>
<td>1. Could not recruit a random sample but did randomize to intervention/control.</td>
<td>1. Attempted to enroll a random sample from community health centers but were unsuccessful in contacting participants and had high refusal. Instead used a CBPR approach and went door-to-door in public housing, churches, businesses, and referrals from women's self-help organization.</td>
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<td>Baseline</td>
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<td></td>
<td>A: 50.3 (81)</td>
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<td>B: 51.9 (82)</td>
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<td></td>
<td>% Difference between groups (95% CI): -1.6 (-12.5 to 9.3)</td>
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<td>Postintervention</td>
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<td>A: 58.7 (91)</td>
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<td>B: 62.1 (95)</td>
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<td>% Difference between groups (95% CI): -3.4 (-14.1 to 7.3)</td>
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<td>Change from baseline to postintervention %, (95% CI)</td>
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<td>A: 8.4 (-2.6 to 19.4)</td>
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<td>B: 10.2 (-2.6 to 19.0)</td>
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<td>% Difference between groups (95% CI): -1.8 (-8.0 to 4.4)</td>
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<td>Mammography (age ≥35) [A. N=141; B. N=137], % (n)</td>
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<td>Baseline</td>
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<td></td>
<td>A: 35.5 (50)</td>
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<td>B: 34.3 (47)</td>
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<td>% Difference between groups (95% CI): -1.2 (-9.2 to 11.6)</td>
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<td>Intervention</td>
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<td>A: 50.4 (71)</td>
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<td>B: 39.4 (54)</td>
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<td>% Difference between groups (95% CI): 11.0 (0.1 to 21.9)</td>
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<td>Change from baseline to postintervention %, (95% CI)</td>
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<td>A: 14.9 (3.5 to 26.3)</td>
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<td>B: 5.1 (-6.3 to 16.5)</td>
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<td>% Difference between groups (95% CI): 9.8 (2.9 to 16.7)</td>
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<tr>
<td>Sung et al., 1997 (continued)</td>
<td>Obtained cancer screening exam on recommended schedule, only those who responded to postintervention survey Pap smear, % (n) [A. N=93; B. N=102] Baseline A: 52.7 (49) B: 50.0 (51) % Difference between groups (95% CI): 2.7 (-11.3 to 16.7) Postintervention A: 63.4 (59) B: 62.7 (64) % Difference between groups (95% CI): 0.7 (-12.9 to 16.7) Change from baseline to postintervention %, (95% CI) A: 10.7 (-3.4 to 24.8) B: 12.7 (-0.8 to 26.2) % Difference between groups (95% CI): -2.0 (-11.0 to 7.0) Mammography (age ≥35) [A. N=80; B. N=94], % (n) Baseline A: 32.5 (26) B: 34.0 (32) % Difference between groups (95% CI): -1.5 (-12.6 to 15.6) Postintervention A: 58.7 (47) B: 47.9 (45) % Difference between groups (95% CI): 10.9 (-3.4 to 25.1) Change from baseline to postintervention %, (95% CI) A: 26.3 (11.3 to 41.1) B: 13.9 (-2.0 to 25.8) % Difference between groups (95% CI): 12.4 (1.0 to 24.3)</td>
<td>(continued)</td>
<td>(continued)</td>
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<tr>
<td>Van Der Wees et al., 2013</td>
<td>Breast: DiD -0.1, p=0.64 Cervical: DiD 2.3%, p=0.02 CRC: DiD 5.5%, p&lt;0.01</td>
<td>NA</td>
<td>Fair</td>
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<td>1. Intervention depends on state policy</td>
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| Williams et al., 2016<sup>13</sup> | A. Postintervention  
B. Baseline  
Hypertensive BP  
A: 34.8%  
B: 45.8%  
p<0.005  
Weight, mean (SD)  
A: 205.2 lbs. (48.3)  
B: 205.9 lbs. (49.2)  
*Note, 20% lost 5+ lbs.  
QOL, physical (100 high)  
A: 47.4 (7.1)  
B: 45.1 (10.1)  
p<0.001  
QOL, mental  
A: 52.7 (8.7)  
B: 52.5 (9.3) | NA | Poor  
1. Study population (absolute risk, demographics, inclusion/exclusion criteria)  
2. Study setting (system, centers, time, effort)  
3. Study providers (training, ancillary providers) |
| Zhou et al., 2014<sup>14</sup> | A: Intervention Vietnamese  
B: Control Vietnamese  
C: Intervention Cambodia  
D: Control Cambodia  
Annual quit ratio, age-standardized 5-year trend  
A: 9.6%, p<0.001  
B: 0.1%, p=0.609  
C: 19.0%, p=0.002  
D: -0.7%, p=0.386  
*Note: increases in intervention groups significantly greater than control groups, p<0.01  
Annual smoking prevalence, age-standardized 5 year trend  
A: -6.4%, p=0.005  
B: -1.8%, p=0.364  
C: 13.9%, p=0.001  
D: -1.6%, p=0.300  
*Note: declines in intervention groups significantly greater than control groups, p<0.05  
Relative disparity decreased (lower smoking prevalence) among A with < high school vs. B and among C with > high school than D  
Relative disparity decreased (higher quit ratio) among A with < high school vs. B and among C with > high school than D | Poor  
1. Groups not comparable at baseline, and no comparison of comparable racial/ethnic group in intervention and control groups  
2. Low response rates  
3. Self-report data  
4. Survey respondents, so likely not same population from start to finish  
5. Unclear whether outcome assessors were masked | Fair  
1. Study population (inclusion/exclusion, demographics, recruitment)  
2. Study setting (system)  
3. Providers (expertise or skill) |
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<tbody>
<tr>
<td>Zhu et al., 2012&lt;sup&gt;15&lt;/sup&gt;</td>
<td>Six-month prolonged abstinence overall</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>A: 16.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B: 8.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>p&lt;0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>OR 2.26, 95% CI 1.73 to 2.94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>A: 14.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B: 6.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>p&lt;0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Korean</td>
<td>A: 14.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B: 5.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>p&lt;0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vietnamese</td>
<td>A: 19.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B: 13.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>p=0.023</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Abbreviations:** ASCVD = atherosclerotic cardiovascular disease; BMI = body mass index; BP = blood pressure; BRFSS = Behavioral Risk Factor Surveillance System; CI = confidence interval; CRC = colorectal cancer; CVD = cardiovascular disease; DiD = difference-in-difference; FOBT = fecal occult blood test; HbA1c = hemoglobin A1c; IQR = interquartile range; ITT = intention-to-treat; NA = not applicable; NHLBI = National Heart Lung and Blood Institute; NR = not reported; NRT = nicotine replacement therapy; NS = not significant; OR = odds ratio; PA = physical activity; Pap = Papanicolaou test; QOL = quality of life; RCT = randomized control trial; SD = standard deviation; SES = socioeconomic status

**Note:** The studies in the above table are a sample of community-based interventions and do not reflect a comprehensive list of all community-based studies found in our search.
Appendix H References


### Appendix I. Strength of Evidence

**Table I-1. Strength of evidence for Key Question 2: Effects of impediments and barriers of populations that contribute to disparities in preventive services**

<table>
<thead>
<tr>
<th>Preventive Service</th>
<th>Barrier</th>
<th>Number of Studies; Study Design; Participants (n)</th>
<th>Study Limitations</th>
<th>Consistency</th>
<th>Directness</th>
<th>Precision</th>
<th>Reporting Bias</th>
<th>Overall Effect</th>
<th>Strength of Evidence; Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal cancer screening</td>
<td>Low income</td>
<td>1 RCT (240)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No effect among safety net clinics</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Insurance</td>
<td>2 RCTs (1,436)</td>
<td>Medium</td>
<td>Inconsistent</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Less screening with Medicare compared with county health plans 1 RCT; no effect in another RCT</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Attitudes</td>
<td>1 RCT* (257)</td>
<td>High</td>
<td>NA</td>
<td>Indirect</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Higher scores on attitudes scale associated with higher screening rates</td>
<td>Insufficient; insufficient</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>Country of origin</td>
<td>1 RCT (1,333)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>More screening with Puerto Rican compared with other non-U.S. born Latinas</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Older age</td>
<td>1 RCT (300)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Less screening for older low-income Chinese immigrants</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Low income</td>
<td>2 RCTs (491)</td>
<td>Medium</td>
<td>Inconsistent</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No effect in 2 RCTs</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Insurance</td>
<td>2 before-after (966); 4 RCTs (3,020)</td>
<td>Medium</td>
<td>Inconsistent</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>More screening with Medicare compared with no coverage in 1 RCT and with insurance in 1 RCT; lower screening rates with insurance in 1 before-after study and 1 RCT; no effect in 2 studies</td>
<td>Low; low</td>
</tr>
<tr>
<td>Preventive Service</td>
<td>Barrier</td>
<td>Number of Studies; Study Design; Participants (n)</td>
<td>Study Limitations</td>
<td>Consistency</td>
<td>Directness</td>
<td>Precision</td>
<td>Reporting Bias</td>
<td>Overall Effect</td>
<td>Strength of Evidence; Applicability</td>
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</tr>
<tr>
<td>Rural</td>
<td>1 cohort study (166)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Less screening with increasing distance from radiologist office and with living in most economically-deprived areas</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>No provider</td>
<td>1 before-after study (737); 1 RCT (300)</td>
<td>Medium</td>
<td>Inconsistent</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Less screening with no regular provider in 1 study; no effect in 1 RCT</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td>1 RCT (300)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No effect among low-income Chinese-American immigrants</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>2 RCTs (1,678)</td>
<td>Medium</td>
<td>Inconsistent</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Higher screening with Puerto Rican compared with other non U.S.-born Latinas; no effect of race in RCT of low-income rural</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Older age</td>
<td>1 RCT (345)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Less screening for older low-income rural</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Low income</td>
<td>1 RCT (345)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No effect among low-income rural patients</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td>3 RCTs (2,246); 1 before-after study (782)</td>
<td>Medium</td>
<td>Inconsistent</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Less screening with Medicare compared with county health plans in 1 RCT and with any insurance in 2 studies; no effect in 1 RCT</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>No provider</td>
<td>1 RCT (705); 1 before-after study (732)</td>
<td>Medium</td>
<td>Inconsistent</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Less screening with no regular provider in 1 study; no effect in 1 RCT</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Preventive Service</td>
<td>Barrier</td>
<td>Number of Studies; Study Design; Participants (n)</td>
<td>Study Limitations</td>
<td>Consistency</td>
<td>Directness</td>
<td>Precision</td>
<td>Reporting Bias</td>
<td>Overall Effect</td>
<td>Strength of Evidence; Applicability</td>
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<td>-------------------------------</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>Racial differences</td>
<td>1 RCT(^a) (314)</td>
<td>Medium</td>
<td>NA</td>
<td>Indirect</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Motivations for smoking differed between African-American and White smokers, but did not explain lower quit rates for African Americans</td>
<td>Insufficient; insufficient</td>
</tr>
<tr>
<td>No provider</td>
<td>1 before-after study (879)</td>
<td>Medium</td>
<td>NA</td>
<td>Indirect</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Having a regular source of healthcare associated with planning to quit within the next 30 days, ever receiving physician advice to quit, and light smoking</td>
<td>Low; low</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: NA = not applicable; RCT = randomized controlled trial.

\(^a\) Secondary data analysis of participants who did not undergo screening.

\(^b\) Mediation analysis of baseline data.
Table I-2. Strength of evidence for Key Question 3: Effectiveness of approaches between providers and patients to reduce disparities in preventive services

<table>
<thead>
<tr>
<th>Preventive Service</th>
<th>Barrier</th>
<th>Number of Studies; Study Design; Participants (n)</th>
<th>Study Limitations</th>
<th>Consistency</th>
<th>Directness</th>
<th>Precision</th>
<th>Reporting Bias</th>
<th>Overall Effect</th>
<th>Strength of Evidence; Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal cancer screening</td>
<td>Patient navigation</td>
<td>2 RCTs (486)</td>
<td>Medium</td>
<td>Consistent</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates in 2 RCTs of Hispanic, African-American, and low-income patients</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Printed materials and telephone counseling if needed</td>
<td>Low</td>
<td>NA</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates among first-degree relatives of colorectal cancer cases for Latinos, Asians, and Whites, but not African Americans</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mailed materials</td>
<td>High</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Higher screening rates in Whites than African Americans</td>
<td>Low; low</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>Reminders with lay health workers</td>
<td>1 RCT(^a) (2,357); 1 non-randomized trial (1,693)</td>
<td>Medium</td>
<td>Consistent</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates among low-income women in 2 trials</td>
<td>Moderate; moderate</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>Reminders with lay health workers</td>
<td>1 nonrandomized trial (1,693)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates among low-income women</td>
<td>Low; low</td>
</tr>
<tr>
<td>Education with video and promotora</td>
<td></td>
<td>1 RCT (443)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates among rural Latinas</td>
<td>Low; low</td>
</tr>
<tr>
<td>Preventive Service</td>
<td>Barrier</td>
<td>Number of Studies; Study Design; Participants (n)</td>
<td>Study Limitations</td>
<td>Consistency</td>
<td>Directness</td>
<td>Precision</td>
<td>Reporting Bias</td>
<td>Overall Effect</td>
<td>Strength of Evidence; Applicability</td>
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</tr>
<tr>
<td>Education with patient navigation</td>
<td>1 RCT (134)</td>
<td>High</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates among low-income Chinese-American women</td>
<td>Insufficient; insufficient</td>
<td></td>
</tr>
<tr>
<td>Obesity Screening and Management</td>
<td>Tailored weight loss delivered by primary care physicians</td>
<td>1 RCT (137)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Improved weight loss in low-income African-American women at 9 months, but not at 12 or 18 months</td>
<td>Insufficient; insufficient</td>
</tr>
</tbody>
</table>

**Abbreviations:** NA = not applicable; RCT = randomized controlled trial.

*Includes reminder letters followed by lay health worker counseling.*
Table I-3. Strength of evidence for Key Question 4: Effectiveness of health system information technologies to improve preventive services in settings that serve populations adversely affected by disparities

<table>
<thead>
<tr>
<th>Preventive Service</th>
<th>Barrier</th>
<th>Number of Studies; Study Design; Participants (n)</th>
<th>Study Limitations</th>
<th>Consistency</th>
<th>Directness</th>
<th>Precision</th>
<th>Reporting Bias</th>
<th>Overall Effect</th>
<th>Strength of Evidence; Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal cancer screening</td>
<td>Electronic decision aid with patient-ordered tests and followup messages</td>
<td>1 RCT (450)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates in low-income patients</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>EHR identified mailings and telephone calls</td>
<td>1 RCT (240)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates in low-income patient</td>
<td>Insufficient; insufficient</td>
</tr>
<tr>
<td></td>
<td>Text messages added to usual telephone calls and mailings</td>
<td>1 RCT (808)</td>
<td>Low</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No differences compared with usual calls and mailings among Alaska Native and American Indian patients</td>
<td>Low; low</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>EHR identified mailings and telephone calls</td>
<td>1 RCT (191)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No effect compared with usual care among low-income patients</td>
<td>Insufficient; insufficient</td>
</tr>
<tr>
<td></td>
<td>EHR triggered reminder letters</td>
<td>1 RCT (1,717)</td>
<td>High</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No effect compared with letter to see physician for referral among low-income patients</td>
<td>Insufficient; insufficient</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>Electronic education modules</td>
<td>1 RCT (943)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No effect compared with mailed materials among low-income Latinas</td>
<td>Low; low</td>
</tr>
<tr>
<td>Preventive Service</td>
<td>Barrier</td>
<td>Number of Studies; Study Design; Participants (n)</td>
<td>Study Limitations</td>
<td>Consistency</td>
<td>Directness</td>
<td>Precision</td>
<td>Reporting Bias</td>
<td>Overall Effect</td>
<td>Strength of Evidence; Applicability</td>
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</tr>
<tr>
<td>Smoking cessation</td>
<td>Counseling by telemedicine</td>
<td>1 RCT (566)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No difference in quit rates among low-income rural patients</td>
<td>Low; low</td>
</tr>
<tr>
<td>Obesity screening and management</td>
<td>Behavioral change counselling with web- or telephone-based patient self-monitoring of progress</td>
<td>1 RCT (365)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Decreased BMI over 24 months in patients of ethnic and racial minorities</td>
<td>Low; low</td>
</tr>
</tbody>
</table>

**Abbreviations:** BMI = body mass index; EHR = electronic health record; NA = not applicable; RCT = randomized controlled trial.
Table I-4. Strength of evidence for Key Question 5: Effectiveness of health system interventions to reduce disparities in preventive services

<table>
<thead>
<tr>
<th>Preventive Service</th>
<th>Barrier</th>
<th>Number of Studies; Study Design; Participants (n)</th>
<th>Study Limitations</th>
<th>Consistency</th>
<th>Directness</th>
<th>Precision</th>
<th>Reporting Bias</th>
<th>Overall Effect</th>
<th>Strength of Evidence; Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal cancer screening</td>
<td>Patient navigation (primary care)(^a)</td>
<td>12 RCTs (25,728); 3 before-after studies (5,691)</td>
<td>Medium</td>
<td>Consistent</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates in all studies except no increase for FOBT at 3 months in 1 RCT</td>
<td>Moderate; moderate</td>
</tr>
<tr>
<td></td>
<td>Patient navigation (community resources)(^b,c,d)</td>
<td>5 RCTs (2,531); 1 non-randomized trial (167)</td>
<td>Medium</td>
<td>Consistent</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates in all studies except 1 RCT comparing multiple enhanced screening interventions</td>
<td>Moderate; moderate</td>
</tr>
<tr>
<td></td>
<td>Provider training(^a)</td>
<td>2 before-after studies (4,092)</td>
<td>Medium</td>
<td>Inconsistent</td>
<td>Indirect</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased colonoscopy rates in one study; no increased rates of rectal exams or FOBT</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Telephone calls and prompts(^a,e)</td>
<td>7 RCTs (54,880); 1 nonrandomized trial (961); 1 before-after study (868,934)</td>
<td>Medium</td>
<td>Consistent</td>
<td>Indirect</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates among underserved patients</td>
<td>Moderate; Moderate</td>
</tr>
<tr>
<td></td>
<td>Screening checklist(^b)</td>
<td>1 RCT (1,196)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates in low-income patients</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Lay health workers(^b,d)</td>
<td>2 RCTs (1,128)</td>
<td>Medium</td>
<td>Consistent</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Practice changes and community engagement(^b)</td>
<td>1 before-after study (97,433)</td>
<td>Medium</td>
<td>NA</td>
<td>Indirect</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates among underserved patients</td>
<td>Low; low</td>
</tr>
<tr>
<td>Preventive Service</td>
<td>Barrier</td>
<td>Number of Studies; Study Design; Participants (n)</td>
<td>Study Limitations</td>
<td>Consistency</td>
<td>Directness</td>
<td>Precision</td>
<td>Reporting Bias</td>
<td>Overall Effect</td>
<td>Strength of Evidence; Applicability</td>
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</tr>
<tr>
<td>Breast cancer screening</td>
<td>Patient navigation&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8 RCTs (9,332); 1 before-after study (91)</td>
<td>Medium</td>
<td>Consistent</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates in all studies; increased for African Americans and other races, but not Hispanics in 1 RCT</td>
<td>Moderate; moderate</td>
</tr>
<tr>
<td>Telephone calls and mailings (primary care)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3 RCTs (1,615)</td>
<td>Medium</td>
<td>Inconsistent</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates in 2 RCTs; no increase in the other</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Telephone calls and mailings (community resources)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2 RCTs (620)</td>
<td>High</td>
<td>Inconsistent</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates for Hispanics, African Americans, and Whites in 1 RCT; no increase in Chinese Americans in the other</td>
<td>Insufficient; insufficient</td>
<td></td>
</tr>
<tr>
<td>Screening checklist&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1 RCT (1,196)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates in low-income patients</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Lay health workers&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2 RCTs (1,048)</td>
<td>Medium</td>
<td>Consistent</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Home visits&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1 RCT (192)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates in rural African-American women</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Patient education&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2 RCTs (341)</td>
<td>High</td>
<td>Consistent</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Practice changes and community engagement&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1 before-after study (97,433)</td>
<td>Medium</td>
<td>NA</td>
<td>Indirect</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates in low-income patients</td>
<td>Low; low</td>
<td></td>
</tr>
<tr>
<td>Preventive Service</td>
<td>Barrier</td>
<td>Number of Studies; Study Design; Participants (n)</td>
<td>Study Limitations</td>
<td>Consistency</td>
<td>Directness</td>
<td>Precision</td>
<td>Reporting Bias</td>
<td>Overall Effect</td>
<td>Strength of Evidence; Applicability</td>
</tr>
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</tr>
<tr>
<td>Cervical cancer screening</td>
<td>Patient navigation&lt;sup&gt;a,b&lt;/sup&gt;</td>
<td>4 RCTs (3,939); 1 non-randomized trial (1,763)</td>
<td>Medium</td>
<td>Consistent</td>
<td>Direct</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening and diagnostic resolution in 3 RCTs and 1 nonrandomized trial; no increase for Hispanics in another RCT</td>
<td>Moderate; moderate</td>
</tr>
<tr>
<td></td>
<td>Telephone calls and mailings&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1 RCT (211)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No differences among 3 intervention groups in colposcopy followup rates</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Screening checklist&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1 RCT (1,196)</td>
<td>Medium</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No increased screening rates in low-income patients</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Lay health workers&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2 RCTs (1,125)</td>
<td>Medium</td>
<td>Inconsistent</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Increased screening rates for Hispanics in 1 RCT but not another</td>
<td>Low; low</td>
</tr>
<tr>
<td></td>
<td>Practice changes and community engagement&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1 before-after study (97,433)</td>
<td>Medium</td>
<td>NA</td>
<td>Indirect</td>
<td>Precise</td>
<td>Undetected</td>
<td>Increased screening rates among underserved population</td>
<td>Low; low</td>
</tr>
<tr>
<td>Obesity screening and management</td>
<td>Patient-focused education sessions</td>
<td>1 RCT (254)</td>
<td>High</td>
<td>NA</td>
<td>Indirect</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>Lower BMI; healthier diet; more exercise among low-income Latinos</td>
<td>Insufficient; insufficient</td>
</tr>
<tr>
<td></td>
<td>Lay health worker, case management</td>
<td>1 RCT (207)</td>
<td>Low</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No differences in BMI among 2 intervention groups of low-income Latinos</td>
<td>Insufficient; insufficient</td>
</tr>
<tr>
<td>Preventive Service</td>
<td>Barrier</td>
<td>Number of Studies; Study Design; Participants (n)</td>
<td>Study Limitations</td>
<td>Consistency</td>
<td>Directness</td>
<td>Precision</td>
<td>Reporting Bias</td>
<td>Overall Effect</td>
<td>Strength of Evidence; Applicability</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
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<td>-------------------------------------</td>
</tr>
<tr>
<td>Lay health worker, patient-focused education sessions, provider counseling, behavior change prescription</td>
<td>1 RCT (217)</td>
<td>High</td>
<td>NA</td>
<td>Direct</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No difference in BMI among 2 intervention groups of underserved Hispanic women</td>
<td>Insufficient; insufficient</td>
<td></td>
</tr>
<tr>
<td>High blood pressure screening</td>
<td>Patient-focused education, counseling, group activities, composite preventive services screening</td>
<td>1 RCT (1,443)</td>
<td>High</td>
<td>NA</td>
<td>Indirect</td>
<td>Imprecise</td>
<td>Undetected</td>
<td>No difference in percentage of participants with high blood pressure among underserved women</td>
<td>Insufficient; insufficient</td>
</tr>
</tbody>
</table>

**Abbreviations:**  
BMI = body mass index; EHR = electronic health record; NA = not applicable; RCT = randomized controlled trial  

a Based in primary care settings.  
b Using community resources.  
c Two RCTs include navigation and lay health workers.  
d One RCT includes navigation and patient education.  
e One RCT included letters, calls, and point-of-care prompts; a before-after study included EHR prompts.