Barriers to Diabetic Care among the At-Risk Population

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Most people with diabetes will develop diabetic retinopathy. Providers need to acknowledge the barriers to care to eliminate non-compliant behavior and improve outcomes. Inner city minority populations of low socioeconomic status lack access to quality medical care or use preventative health services, becoming at-risk for further complications.

Learning Objectives

- Recognize risk of diabetic retinopathy in at-risk patients with barriers to care.
- Recognize barriers to care using the 5A framework including: 1) access, 2) availability, 3) affordability, 4) awareness, and 5) attitude
- Understand the recommendations in breaking barriers down using the 5P’s: 1) place, 2) personnel, 3) procurement, 4) promotion, and 5) perception.
- To provide an at-risk population with the tools and resources necessary to overcome barriers to care.

Outline

1) Background
   a) Diabetes is a significant public health problem in the U.S.
   1. 25.8 million people (8.3% of the population) are affected, with 18.8 million diagnosed and 7 million undiagnosed (in 2011)
   2. 26.9% are 65 years and older, which is the fastest growing subsection of the population
   3. Diabetes related complications cost an estimated $174 billion in 2007
   b) Diabetes is the leading cause of new blindness in 20-74 year age group
   1) 4.2 million people (28.5% of people with diabetes over 40 years old) have diabetic retinopathy
   2) 655,000 (4.2% of people with diabetes) have advanced diabetic retinopathy
c) Both the prevalence of diabetes and diabetic retinopathy will increase with the changing demographic trends, including increasing obesity and an aging population.

d) At-risk populations and barriers to care
1. Disparity in health status among minorities-care that exists between Anglo and minority populations has been a recognized problem with minorities having poorer health than Anglos.
2. Inner city minority populations-often without the ability to access quality medical care.
3. Low socioeconomic status-patients of low SES exhibit more severe morbidity. Diabetic patients with a lower SES are less likely to receive a specialist care or use preventive health care services, thus becoming at-risk for complications of the disease.

e) Case study example: South Jersey Eye Center, Camden, New Jersey
1. History-South Jersey Eye Center (SJEC) located in Camden City, is a non-profit charitable 52 year old organization. The SJEC provides eye health, eye vision screenings and comprehensive examinations to the underserved population. The SJEC has documented over 500 diabetic patient visits in the past year (2011-2012)
2. Population – Camden is home to a diabetic population that far exceeds the national averages. The Camden Coalition of Healthcare Providers has identified 7,041 residents in Camden living with Type 2 Diabetes. Over a six year period, these patients have accounted for over 62,000 visits to emergency rooms in Camden hospitals.
3. Access to care-affected by factors such as employment, education, health insurance, transportation, geographic location, and SES.
2) **Barriers**
   
a) **Access** – geographic location, SES, language barrier, safety of facility: limited access to health care is associated with poor outcomes in many chronic illnesses such as diabetes.

b) **Availability** – limited personnel and technology, limited physicians in rural areas. Availability measures to what extent the provider has requisite resources to meet the needs of the individuals. Personnel often not trained effectively to meet the needs of the underserved population coming from the same community with limited knowledge.

c) **Affordability** – Lack of health insurance or underinsured, direct and indirect costs, low income status. Uninsured or underinsured patients do not get the care they need or postpone care for a long time. Patients will not seek out preventative care. Longstanding disparities in groups at risk for diabetes is a direct effect of low income and is both a direct and indirect financial barrier to access. The cost of illness is an economic shock for poor families resulting in a higher economic burden.

d) **Awareness** – lack of education, lack of knowledge of existing, available services, no involvement with other social organizations or agencies. Low levels of education contribute to low life expectancies and high mortality rates. No involvement with other social services or agencies and have not sought care for other conditions.

e) **Attitude** – non-compliant patient, behavioral habits, physician bias, stereotyping. Behavioral changes in the physician, health care system, and patient are important to ensure better quality of care.

3) **Recommendations**
   
a) **Place** – Community Health Centers, Mobile Health Clinic, alternate hours. SJEC provides a “family” style welcoming approach to eye care focusing on the needs of the patients on an individual basis. Mobile Vision Clinic provides care to people who have no other way of obtaining eye care, thus making health care more easily accessible.
b) **Personnel** – training of professionals, provision of students from nearby teaching hospitals/universities, professionals from other clinics to volunteer time. Doctors need adequate resources to treat conditions. Provision of education and training of professionals with adequate skills to address the health care of needy populations is necessary. In the past, a nearby teaching facility such as Salus University has been instrumental in providing students to the SJEC to assist with patient care – at no cost to the Center. Volunteer services from within the SJEC and other facilities to help with direct costs of patient care.

c) **Procurement** – Increase reimbursement levels, e.g. Medicaid, improved price controls, increased funding sources for services and materials. Reduce the overall costs of health care and decrease the number of uninsured Americans, hence The Affordable Care Act. Increased funding sources would aid in keeping costs down in non-profit facilities such as the SJEC.

d) **Promotion** – training health workers to raise awareness, educating population of existing health resources, promoting health programs in community. Every health care encounter provides the opportunity to help or educate the patient to receive optimal care and solicit information for the welfare of the patient.

e) **Perception** – person-centered approach, building trust with patient, staff training to assist with patient behavioral change, value patient. Health care workers need behavior change training to assist patients in adjusting their attitudes and behaviors to comply with the suggested and recommended treatment. Understanding how patients feel will enhance their overall health care experience resulting in a good attitude about their outcome.

4) **Management of Care**

a) Awareness of barriers for management of diabetes-if barriers are not broken, care management becomes very difficult for the professional as well as the patient. Important to be aware of barriers in order to tailor diabetes care and services to accommodate individual socioeconomic and cultural needs.

b) Health education efforts-positive outcomes are achieved when patients are well educated regarding their disease, care, and management.
c) Interdisciplinary collaboration with other specialties—providing adequate diabetes management for the patient.

5) Conclusions—Understanding barriers will have a direct effect on moving from the acute care model to one that focuses on long-term preventative and management care.