Preface

Amparo Gonzalez, RN, CDE, FAADE, Guest Editor

During the past 6 years, I have dedicated my skill and knowledge as a diabetes educator to the care of ethnic minorities of low socioeconomic status. Working with this population has presented me with multiple challenges, but also with many rewards. It is my privilege to present to you this Diabetes Spectrum From Research to Practice section addressing vulnerable populations and diabetes.

Diabetes is a serious health problem that disproportionally affects minority populations. The Centers for Disease Control and Prevention projects that if the current trend continues, one in three children born in the United States after 2000 will develop diabetes; for ethnic minorities, including blacks and Latinos, one in two children will develop diabetes.1

In the literature, many terms are used when addressing the topic of equity in health, such as “vulnerable populations,” “health disparities,” and “social determinants of health.” The Agency for Healthcare Research and Quality defines vulnerable populations as those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or development status, ability to communicate effectively, and presence of chronic illness or disability.2 The National Partnership for Action to End Health Disparities, a program of the U.S. Department of Health and Human Services (DHHS) Office of Minority Health, defines health disparities as a particular type of health difference that is closely linked with social or economic disadvantage.3 These differences can be affected by determinants of health, including a range of personal, social, economic, and environmental factors that influence health status. Vulnerable populations experience health disparities as a result of social and physical determinants of health. It is integral, then, that as we look into what makes some people healthy and others unhealthy, we address social and physical determinants of health.

Healthy People is a document released by the DHHS each decade. It is a set of goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts to improve the health of all people in the United States. Healthy People 2000 introduced measures aimed at reducing health disparities. The current public health agenda vision is a society in which all people live long, healthy lives. It also includes an overarching goal aimed at achieving health equity, attaining the highest level of health for all people, eliminating health disparities, and improving health in all people in the United States.

Diabetes is a topic area included in Healthy People 2020. The diabetes goal is to reduce the disease and its economic burden and to improve the quality of life of all people who have or are at risk of developing diabetes. Some of the interventions addressing the diabetes objective speak to issues such as diagnosis, prevention, and measurement of clinical indicators of care. But the objective also gives special attention to the importance of those diagnosed with diabetes receiving formal diabetes education.4

Although the national public health agenda continues to address the elimination of health disparities in diabetes, vulnerable populations still experience a higher prevalence, greater severity of complications, and greater mortality rate from this condition. As provid-
ers of diabetes care, our efforts target individuals with diabetes and related comorbidities. However, we observe that the prevalence of diabetes and its devastating consequences continue to exceed projections. To achieve the goal of our current public health agenda, Healthy People 2020, efforts that address avoidable inequalities, historical and contemporary injustices, and healthcare disparities will require a broader reach at levels that affect the entire society, from individual-focused interventions to legislative initiatives. 

To illustrate problems affecting vulnerable populations with diabetes, we invited an outstanding group of experts to share their research and expertise on this topic. These articles address promising practice interventions targeting individuals, providers, communities, health systems, policies, and laws. The vulnerable populations addressed include ethnic minorities, food-insecure individuals, those with limited English proficiency, Native American and Alaska Native youth, and women with gestational diabetes.

Leonard Jack, Jr., PhD, MSc, and his colleagues start the discussion with their article on “Social Determinants of Health in Minority Populations: A Call for Multidisciplinary Approaches to Eliminate Diabetes-Related Disparities” (p. 9). They describe current approaches addressing diabetes prevention and control based on the belief that individuals are solely responsible for adopting and maintaining modifications of lifestyle practices. Diabetes care interventions studied in clinical and community-based studies are not easily translatable into practical approaches that can help eliminate diabetes-related comorbidities. These authors discuss interventions that provide a broader scope, including community, environment, policy, and law that can affect both physical and social determinants of health. Their article examines the importance of developing nontraditional strategies and partners to identify opportunities for preventing and improving health outcomes in communities affected by factors impeding health equity.

Next, Andrea López, BS, and Hilary K. Seligman, MD, MAS, address “Clinical Management of Food-Insecure Patients With Diabetes” (p. 14). These authors report that one in seven households in the United States struggled to afford adequate food in 2010. Food insecurity encompasses a range of experiences and behaviors depending on its severity. Individuals who experience food insecurity are at risk for diabetes, and those who have diabetes are at higher risk of hypo- and hyperglycemia. This article discusses methods of screening individuals for food insecurity and provides strategies for helping food-insecure individuals with diabetes prevent hypo- and hyperglycemia.

Our third article, “Language and Health Care” by Yolanda Partida, MSW, DPA, (p. 19), emphasizes that effective communication is a key marker of high-quality health care. Shared language enables information-gathering for diagnosis, allows for clear explanation of treatments, and ensures understanding and joint decision-making between providers and patients. Noting that the United States, a nation of immigrants, has adopted English as its language, she discusses the effects of language barriers on social and economic integration. She describes how patients’ health literacy affects their understanding of health information, and shares lessons for improving health communication in multilingual populations.

In “Type 2 Diabetes Science and American Indian/Alaska Native Culture: Creating a National K-12 Curriculum Prevention Strategy for Native Youth” (p. 23), Carolee Dodge Francis, EdD, and Michelle Chino, PhD, report that preventing type 2 diabetes among American Indians and Alaska Natives requires innovative approaches. They describe the cultural and scientific development of the Diabetes Education in Tribal Schools curriculum as a targeted health prevention strategy. This curriculum, made available to teachers of kindergarten through twelfth grade, aims to prevent type 2 diabetes by improving students’ knowledge, attitudes, and cognitive decision-making skills.

In our next article, “Interventions to Increase Access to Care and Quality of Care for Women With Gestational Diabetes” (p. 26), Michelle D. Owens-Gary, PhD, and Joan Ware, BSN, MSPH, discuss prevention of gestational diabetes mellitus (GDM) in the United States. GDM is increasing; in some populations, the prevalence ranges from 3 to 14%. The true prevalence of GDM may be higher because underreporting is a serious problem.

These authors present the results of The GDM Collaborative: Better Data, Better Care, a multisite pilot study to evaluate GDM diagnosis documentation in medical records as a mechanism for identifying women with a history of GDM and their offspring. The authors describe research conducted in Utah to improve GDM documentation in medical records and in West Virginia to address GDM intervention strategies in a tertiary care outpatient clinic. Increasing access to care for women with GDM requires improvements in public health surveillance of this condition. This article shows us how such improvements can be accomplished.

There is no single solution to address the vulnerabilities faced by population groups affected by health disparities. Instead, multiple approaches are necessary that are tailored to the specific target population group and its environment. Providers should assess the vulnerabilities of their individual patients in relation to those patients’ community and environment to determine actions that can help to eliminate health disparities within these and other vulnerable populations.

**References**


Diabetes Spectrum Volume 25, Number 1, 2012