IDENTIFICATION OF DIABETIC COMPLICATIONS AMONG MINORITY POPULATIONS

Jay J. Shen, PhD; Elmer L. Washington, MD, MPH

INTRODUCTION

Given the increasing prevalence of type 2 diabetes associated with the growing prevalence of obesity, studies that evaluate the effectiveness of the healthcare system for meeting the needs of diverse populations are critical to improving outcomes and limiting unnecessary morbidity. Approximately 19 million Americans have diabetes at a direct cost of $40 billion.1,2 While research on disparities across diverse ethnic groups and conditions has shown varying causes potentially related to the type of disease considered,3 in-depth research on type 2 diabetes outcomes at the national level is sparse.4,5

Further, limited research on type 2 diabetes has been conducted on national samples or correlated ethnicity with stage of disease progression. Although findings from multiple studies on disparities describe several contributing factors, including care-seeking behaviors, access to ambulatory care as opposed to reliance on the emergency department, and emphasis on health promotion,6,7 relatively few studies have evaluated a disease in which several of these factors can concurrently exert an influence. Since care outcomes for type 2 diabetes have multiple determining factors, including adherence to recommended lifestyle changes,8,9 adherence to medications,10–12 consistency of follow up,13 and locus of control,14,15 racial and ethnic disparities that occur with respect to diabetes care may have root causes associated with any of them. Therefore, by examining patterns of care for type 2 diabetes by ethnicity, we sought to describe disparities, evaluate potential multifactorial causes, and create an agenda for eliminating disparities that can improve outcomes across a wide variety of chronic conditions.

METHODS

Data

We abstracted adult discharges from the cross-sectional 2003 National Inpatient Sample (NIS), representing 20% of US community hospitals, defined by the American Hospital Association. The community hospitals are nonfederal, short-term, general, and other specialty hospitals. Short-term rehabilitation hospitals, long-term hospitals, psychiatric hospitals, and alcoholism/chemical dependency treatment facilities are excluded. The NIS data are collected by the Hospital Cost and Utilization Project, sponsored by the Agency for Healthcare Research and Quality. Based on the International Classification of Diseases, 9th Edition, Clinical Modification.