Diabetes is expensive. Diagnosed diabetes [costs America](http://www.diabetes.org/diabetes-basics/statistics/infographics/adv-staggering-cost-of-diabetes.html) $327 billion per year. People with diabetes have expenditures that are [2.3 times greater than those without diabetes](http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html). It comes as no surprise that diabetes is one of the most [costly diseases for commercial health payers](https://www.ceceliahealth.com/blog/the-true-cost-of-diabetes-to-health-insurance-organizations).

The good news is that we can be smarter about approaching this problem. Certain populations are at much higher risk for complications that increase the per-member cost. With the right help and guidance, the vulnerable members of your organization’s health plans can better manage their conditions and improve their individual health outcomes, which, in turn, improves your ROI and quality measures.

What, then, are your most at-risk and vulnerable populations and how do you help them? We’ve done the research and outlined them below.

1. **Low health literacy populations**

The [Office of Disease Prevention and Health Promotion](https://health.gov/communication/literacy/issuebrief/) found that more than a third (77 million) of U.S. adults have only basic or below basic health literacy. In fact, only 12 percent of people demonstrate proficient health literacy. More than a third of people are not being familiar with medical terms or how the human body works. If you have a complex condition that requires complicated self-care like diabetes, this is a huge barrier to recovery and staying healthy. Studies have shown that [higher health literacy is strongly correlated with better glycemic control in adults with type 1 diabetes](https://drc.bmj.com/content/5/1/e000437). If a patient doesn’t understand medical terms and have low health literacy, they can’t understand what’s happening to them or how they can make it better, often leading to poorer health outcomes.

1. **The chronically ill or disabled**

Those with chronic diseases are often at higher risk of poor health outcomes, therefore using more healthcare dollars than healthy individuals. After all, the chronically ill are [twice as likely](https://www.ajmc.com/journals/supplement/2006/2006-11-vol12-n13suppl/nov06-2390ps348-s352) to report poor health days as the general population. Those with disabilities, despite their many interactions with the health system, might have difficulty accessing care and face [special challenges](http://govinfo.library.unt.edu/hcquality/meetings/mar12/papch08.htm) in obtaining services. This leads to lower health overall.

1. **Low-income individuals**

Diabetes is a disease that disproportionately affects low-income individuals; low-income individuals more likely to have chronic illnesses to begin with.

To add to the burden, diabetes self-management is especially difficult people who struggle with financial resources, since nearly every facet of self-managing a diabetes diagnosis is severely limited by being low-income.

From reliable access to medication to food insecurity to lack of safe and affordable exercise and low health literacy, barriers to sufficient diabetes management plague low-income individuals. People with lower incomes are also [more likely to have co-occurring conditions](https://www.commonwealthfund.org/publications/journal-article/2018/feb/income-disparities-prevalence-severity-and-costs-co-occurring) that might make it difficult to stay healthier, whether it’s depression or substance use problems or comorbid and chronic medical conditions like obesity.

1. **Members in rural areas**

For Americans living in rural areas, maintaining good health is often more difficult than for the general population. The reason? Rural populations [experience geographic isolation, have a lower socioeconomic status, have limited job opportunities, and tend to be older](https://www.ruralhealthinfo.org/topics/rural-health-disparities).

Because of the geographical isolation and other traits, rural populations often have trouble [getting the care they need](https://www.nytimes.com/2018/07/17/us/hospital-closing-missouri-pregnant.html), which is a problem when managing a complex disease like diabetes.

1. **Non-English-speaking members**

We live in the States, and in this melting pot, it’s possible that some of your members simply don’t speak English. This is a vulnerable population because these members may have difficulty interpreting care providers, prescriptions, and other healthcare instructions. The unfamiliarity with English can also be linked to discomfort and distrust in the healthcare system, in general lowering a patient’s ability to follow through on diabetes self-management instructions. The domino effect follows: worse patient outcomes means higher costs for the payer and the healthcare industry at large.

1. **People predisposed with higher risk**

Diabetes and healthcare are not above the racial and social justice issues of our country. Certain racial and ethnic groups might be more at-risk than others. Studies have shown that African Americans and Hispanics are [over 50 percent more likely](http://www.diabetes.org/assets/pdfs/basics/cost-of-diabetes-2017.pdf) to have diabetes than non-Hispanic whites. Unfortunately, blacks and Hispanics also have the [lowest health literacy](https://health.gov/communication/literacy/issuebrief/) among racial/ethnic groups, with 65% of black and Hispanic people being at a below basic level.

Data from the [Centers for Disease Control and Prevention (CDC) and Indian Health Service](http://spectrum.diabetesjournals.org/content/23/4/272#ref-1) (IHS) has shown that certain American Indian and Alaska Native communities have sprouted diabetes prevalence rates as high as 60%, and one in six American Indian and Alaska Native adults has diagnosed diabetes.

These populations might be unable to access care, partly because their health programs are [underfunded](https://www.npr.org/sections/health-shots/2016/04/13/473848341/health-care-s-hard-realities-on-the-reservation-a-photo-essay), or face discrimination when they go to doctors and health clinics. For example, [NPR recently reported](https://www.npr.org/sections/health-shots/2017/12/12/569910574/native-americans-feel-invisible-in-u-s-health-care-system) that one-fourth of Native Americans have said they experience discrimination when they seek traditional healthcare.

**How do you help these at-risk members?**

The struggles of each vulnerable population are not mutually exclusive to each one; many populations overlap and [face similar barriers](https://www.ceceliahealth.com/blog/the-4-biggest-barriers-to-medication-adherence-for-diabetes-patients) that negatively impact their ability to seek out help in managing their own condition. How do you help these members?

At Cecelia Health, our approach has been [clinically proven to improve diabetes health outcomes](https://www.ceceliahealth.com/improving-diabetes-health-through-scalable-personalized-coaching/) through scalable, personalized coaching, an approach that works especially well when focused on high-risk, poorly controlled populations who face unique barriers or would otherwise not seek help. Our technique of combining this personalized coaching program that utilizes Certified Diabetes Educators (CDE) with outcome-tracking technology has proven successful in improving self-management and drives behavior change. Because of the personal, one-on-one relationships patients build with CDEs, a patient’s individual diabetes-management barriers can be identified and addressed. CDEs get to know each patient as a person, much more than just a medical history.

With this combination of CDE clinical coaching and technology-enabled platform for tracking health outcomes, Cecelia Health has been able to help health plans improve the health of their vulnerable and at-risk members with diabetes with measurable impacts on Star, HEDIS, and Healthy Days metrics.