

2. The Impact of Research on Program Success

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THE ARTICLE BY MARY E. STUART ON THE FINANCING and care of diabetes in Maryland describes a program that effectively encourages state funding of preventive health services for people with diabetes. Stuart links the ability to obtain future third-party reimbursement for preventive services in part to the findings and potential impact of the Diabetes Control and Complications Trial (DCCT). Perhaps more valuable, however, is the insight that she offers into scenarios that encourage changes in health care delivery and influence policy developments. Elements found in the setting of her study that merit a brief review are listed and briefly described:

- Timeliness/receptivity of the scientific community
- Adaptable intervention program
- Short- and long-term treatment outcomes
- Prevalence of the disease
- Financial incentives
- Pilot data
- Opportunistic programming

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Timeliness/Receptivity of the Scientific Community

The developers of the Maryland program were able to take advantage of a scientific community that was responsive to improving care for diabetes. The fact that the DCCT was the most expensive randomized clinical trial ever carried out by the National Institutes of Health sent a signal to the medical community that researchers viewed the improvement of care for people with diabetes as a matter of national importance. The results of the DCCT may not have been available when the Maryland project began, but the commitment to diabetes research was a crucial factor.

Adaptable Intervention Program

Effective patient education programs for diabetes and continuing medical education programs for health professionals have been documented in the medical literature. These programs are labor intensive, and they provide basic training skills and information that can be easily used to improve the management and care of persons with diabetes.

Short- and Long-Term Treatment Outcomes

Short- and long-term improvements in diabetes care can be demonstrated following intervention programs. Timely improvements encourage investments in preventive care. Attention to improved management will prevent unnecessary admissions for diabetes ketoacidosis in Type I cases. It is more difficult to provide convincing data to support the thesis that preventive care today will prevent comorbid complications among Type II cases. This kind of evidence will probably take years to develop.

Prevalence of the Condition

Approximately 10 to 14 million people have diabetes. Of this total population, roughly 90 percent are not insulin users. As the population ages, the prevalence of diabetes grows, increasing the burden on Medic-

aid programs. For example, the prevalence of diabetes among adult nursing-home patients is estimated to be 20 percent. Preventing complications and coexisting morbidities of diabetes will improve the health of millions of people and will save substantial amounts of health care dollars.

Financial Incentives

The Maryland Medicaid program reported a deficit of 13 million dollars in 1989. The magnitude of these costs spurred policy makers to consider alternative ways of providing care.

Promising Pilot Data

Preliminary data from the Maryland program indicated that the average cost per person for Medicaid recipients was three times higher for those with than for those without diabetes. An intervention program that targeted persons most at risk of complications could result in substantial savings for the subset of Medicaid patients with diabetes.

Opportunistic Programming

In Maryland the Office of Chronic Disease and the Medicaid office were located in the same building, giving the staff of the two units the opportunity to interact, share ideas, and collaborate on projects. The significance of the interaction is difficult to assess, but the outcome suggests that the cross-fertilization of ideas can be fruitful when there is a workable forum for exchange.

These seven elements operated in concert to provide the basis for creating the Maryland Medicaid Diabetes Care Program. Treatment effectiveness findings or results from other clinical studies on diabetes were not a driving force in the success of this program. The information on successful intervention programs, which had been available from the medical literature for some time, was important, however. The Maryland program worked because of a timely combination of factors reflecting the

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policy, financial, and data needs of the state Medicaid program. Sometimes the research environment, as represented by the ongoing, but unfinished, DCCT study, facilitates the adoption of a new program. Now that Medicaid reimbursement is available, the DCCT results may initiate a snowball effect that attracts other insurers.

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