A disease management program reduced hospital readmission days after myocardial infarction


Why are DMPs not more widespread? One reason may be that Medicare and other insurance programs usually define benefits on a limited scope of services, while chronic illnesses (i.e., CHF and diabetes) require ongoing management. A second reason is that no universal model or well-defined set of key features exists, and programs by definition differ from study to study. Third, existing studies are small, diffuse, and not widely or prominently published. As such, it is not clear from the literature which conditions are best suited for DMPs and how best they are constructed. Cost-effectiveness is another issue that is diffuse, and not widely or prominently published. As such, it is not clear from the literature which conditions are best suited for DMPs and how best they are constructed. Cost-effectiveness is another issue that is not fully established, although reduced hospital days intuitively offer the opportunity to offset some of the cost per patient.

Every DMP is different and should be evaluated by a clinician on its own merits. However, it should be recognized that a good program has tremendous potential to keep sick patients well managed and out of the hospital.

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A disease management program (DMP) more effective than usual care for reducing hospital readmission days for angina, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD)?

In patients recovering from myocardial infarction (MI), is a disease management program (DMP) more effective than usual care for reducing hospital readmission days for angina, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD)?

The study by Young and colleagues adds to the growing literature showing the effectiveness of DMPs for cardiovascular disease. In this study, “inner-city” patients were presumably disadvantaged with regard to both finances and the adequacy of follow-up care. This cohort of patients may be even more common in the United States, which has no nationalized system to minimize health insurance obstacles. As with other DMPs, the findings in this study support their use by reducing hospital readmission days. This and previous studies have been underpowered to detect a difference in such hard endpoints as reinfarction and mortality.

Some physicians may have worked with a well-constructed and finely honed DMP and are aware that large trials are not necessary to prove the efficacy of these programs. The difficulty seems to be defining the program and identifying the key participants and which crucial elements are necessary for success. For example, physicians who are unaccustomed to specialized nurses who make frequent and ongoing visits may be uncomfortable with prewritten diuretic titration orders. However, such a simple function may well be a critical measure for keeping CHF patients well and at home.