

Northern Network of Cardiac Care

**“Can practice based
commissioning reduce
re-hospitalisation?”**

Dr Michael Chester

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**Director of the National Refractory Angina Centre,
RLBUHT Liverpool.**

Secondary Care Providers

- **Expensive**
- **Paternalistic**
- **Needs radical reform**

Annual waste (potential savings)

- Avoidable (unnecessary) admissions
- Avoidable (unnecessary) treatments

Total NHS > £2,000,000,000

Average PCT = £14,000,000

30,000 list > £1,000,000

Institute for Innovations and Improvement

cost saving recommendations

- Identify conditions accounting for disproportionate level of admissions
- Local feedback to GPs on 'high cost' patients
- Develop alternative thought process
 - Move from 'admit to decide' systems
- Use PBC to develop alternative care pathways

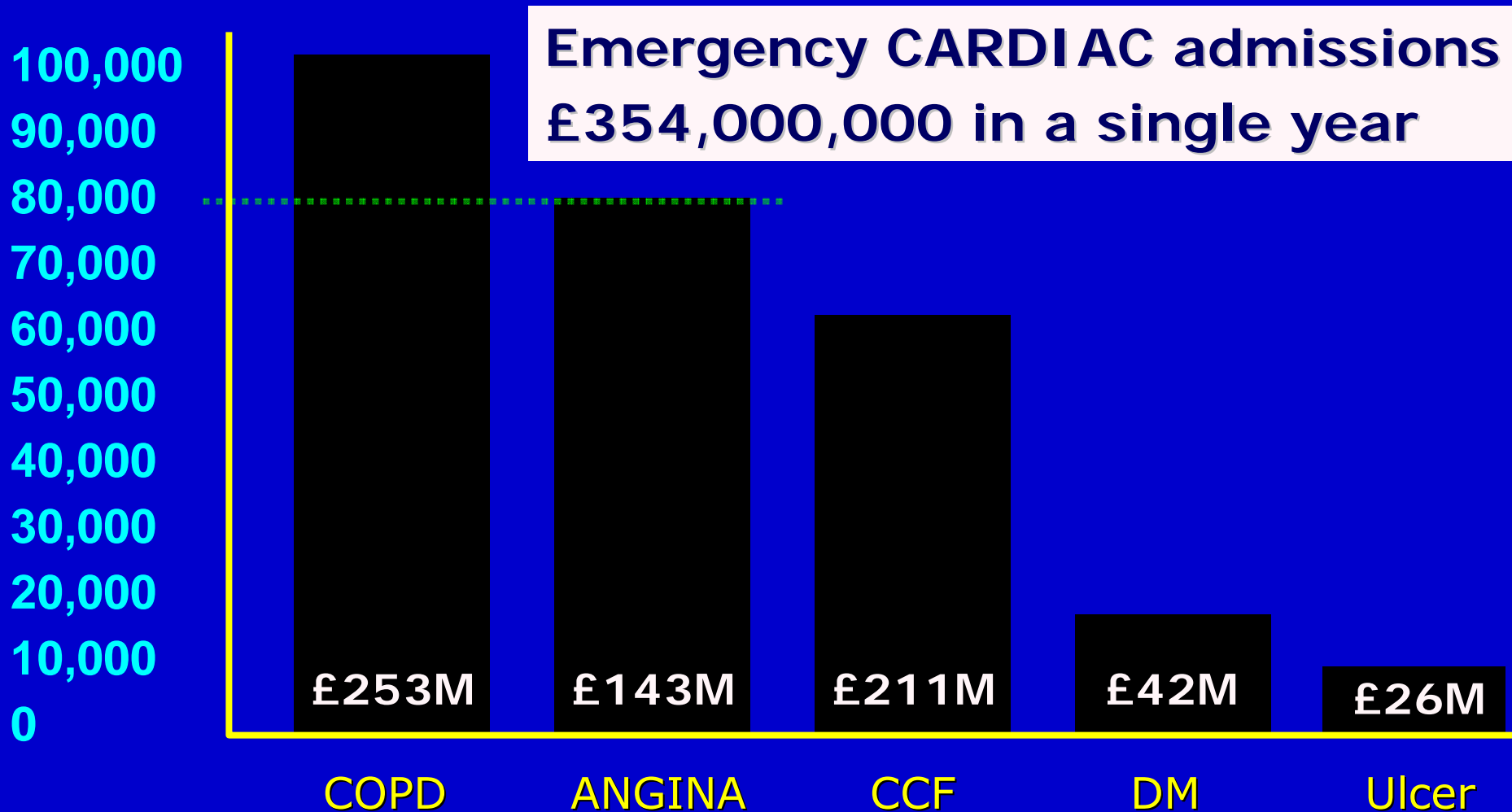
Commissioners' view of cardiology



PBR: Incentives to cost saving service redesign

- **“Surplus”** (*depending on point of view*)
 - = saved expenditure
 - = waste avoided
 - = reduced income to secondary care
- **Around 70% of savings (suggested by DH) can be redeployed to the “saver” to enhance primary care services**

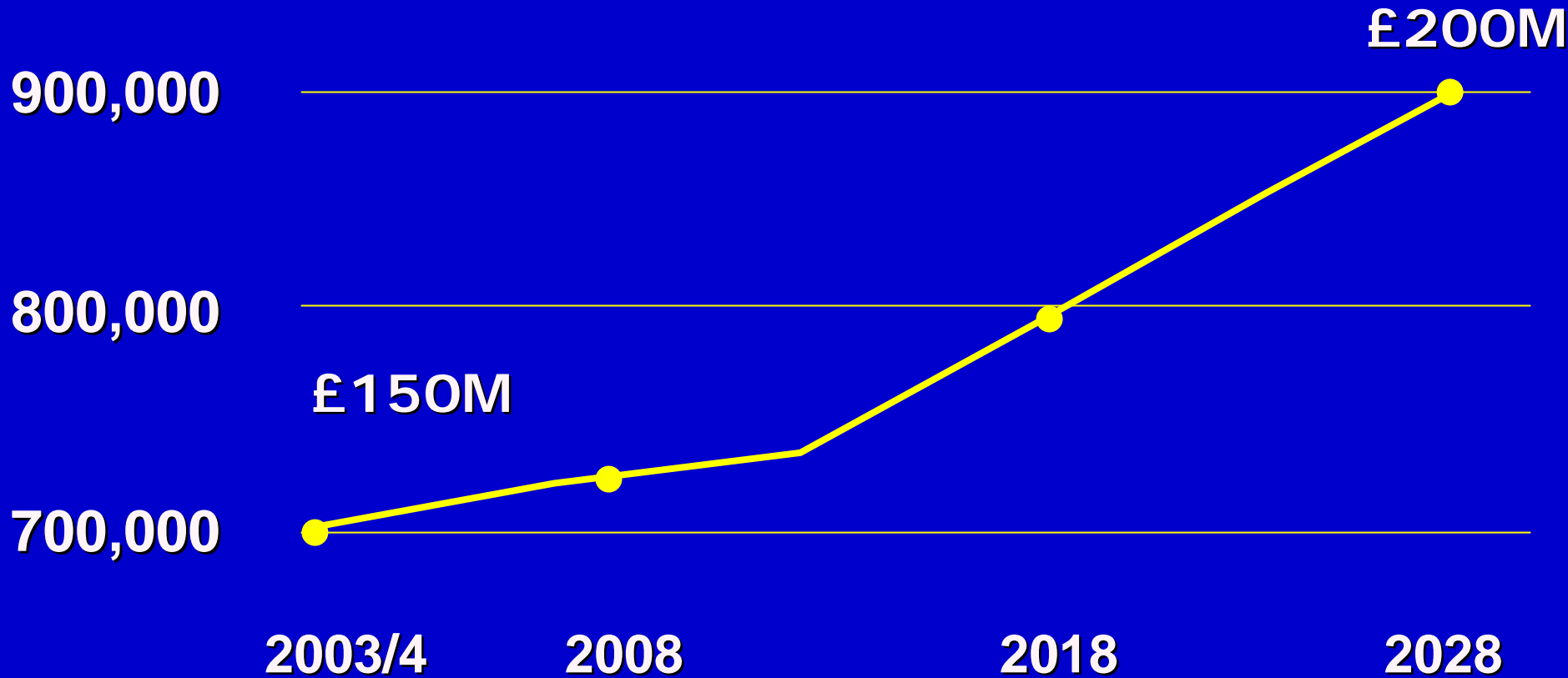
Emergency admissions & annual costs (millions) 2003/4



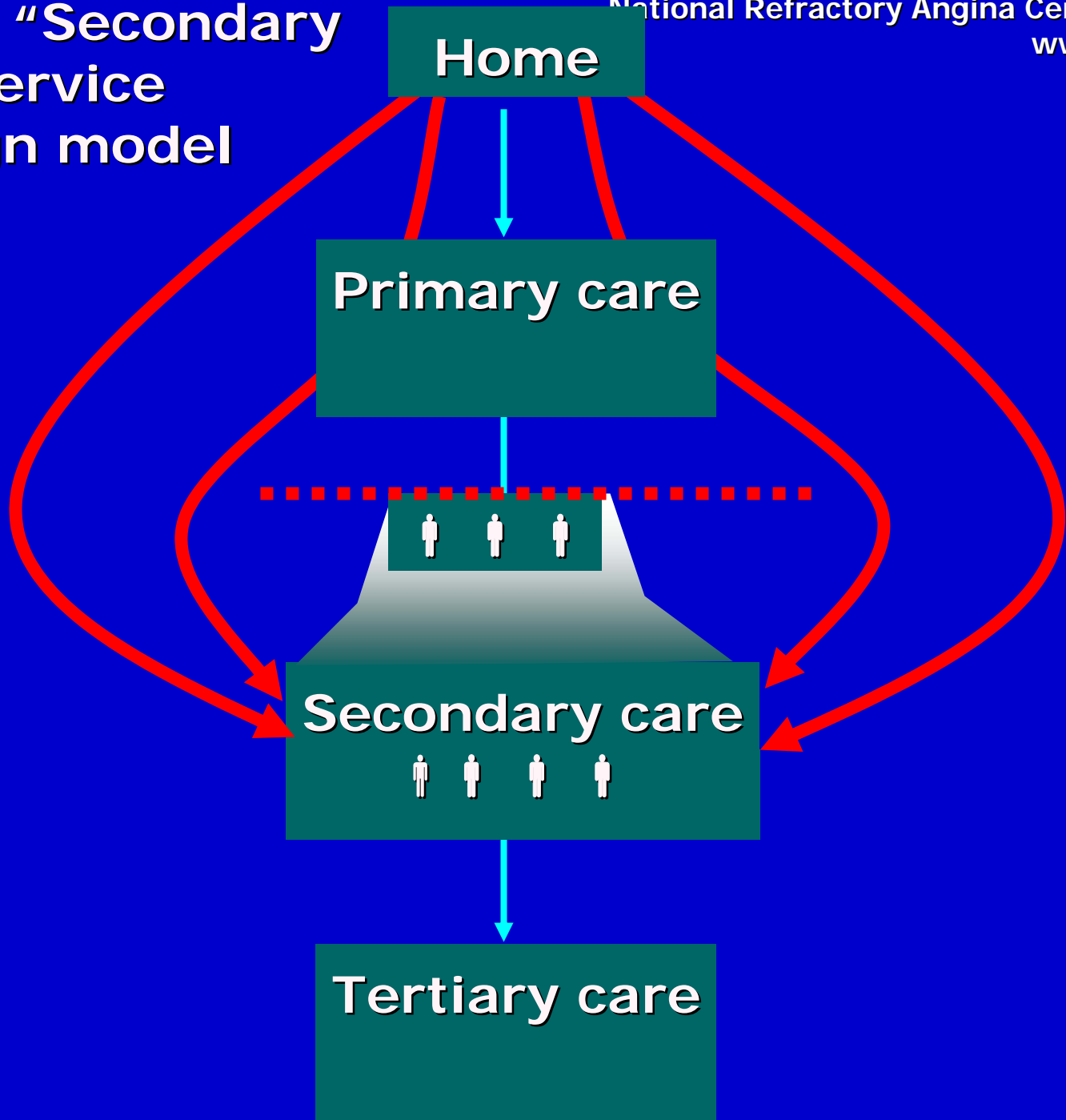
Dr Foster Unplanned chest pain admissions



Projected emergency in-hospital days for chest pain



Typical "Secondary care" service redesign model



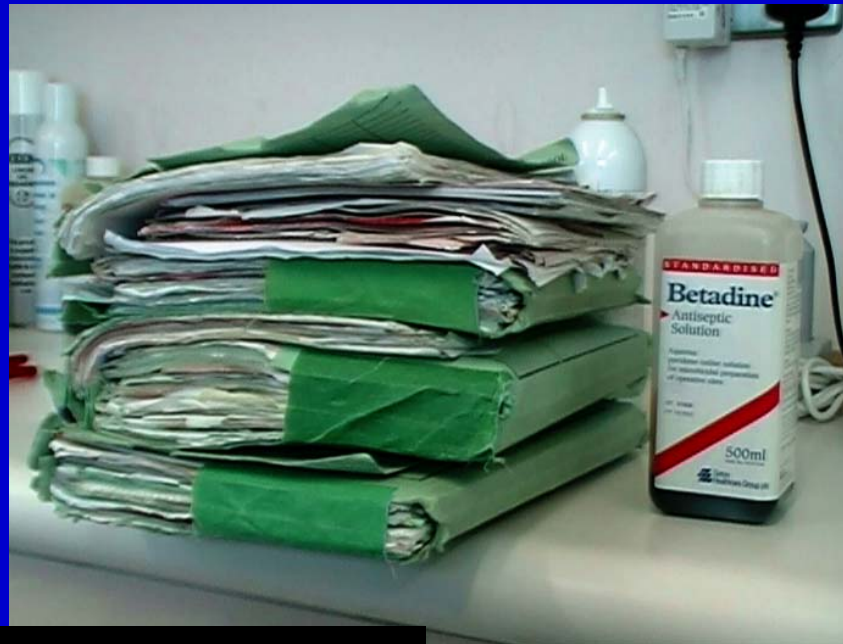
First NRAC referral 1995

1975-1995

- CABG x 3
- PTCA x 5
- TMLR x 1
- Multiple admissions

≈ £500,000

= £25,000 year⁻¹



Suggestions for patient X with 2 prior CABGs, 3 PTCAs & Refractory angina at major UK centres 1996/7

EECP

Gene Rx

Intrathecal opioids

Urokinase

EDTA

Redo-redo CABG

Temporary sympathectomy

Destructive sympathectomy

Spinal cord stimulation

Cognitive behavioural therapy

Transplantation

Opioids

Laser

I can always PTCA something

Transcutaneous nerve stimⁿ

Ask patients what they want

“Making consent patient centred”

John Bridson, Clare Hammond, Austin Leach &
Michael R Chester

BMJ 2003;327;1159-1161

doi:10.1136/bmj.327.7424.1159

ACC/AHA/ACP–ASIM Stable Angina Guidelines

Gibbons et al Circ 1999; 99: 2829-2848

1. Assess the patient's baseline understanding.
- 2. Elicit the patient's desire for information.
- 3. Use epidemiological and clinical evidence.
- 4. Use ancillary personnel and professional patient educators when appropriate.
- 5. Use professionally prepared resources when available.
- 6. Develop a plan with the patient.
- 7. Involve family members in educational efforts.
- 8. Remind, repeat, and reinforce.

NRAC new patients' angina beliefs n=193

agree

Angina is caused by a worn out heart 26%

My angina was caused by having too much worry or stress at work 42%

An attack of angina does not do you any lasting harm 38%

If you get angina it will definitely shorten your life whatever age you are 39%

If I get an attack of angina I just wait for a few minutes then carry on 58%

It's better to put up with a bit of angina than to miss out on the fun in life 46%

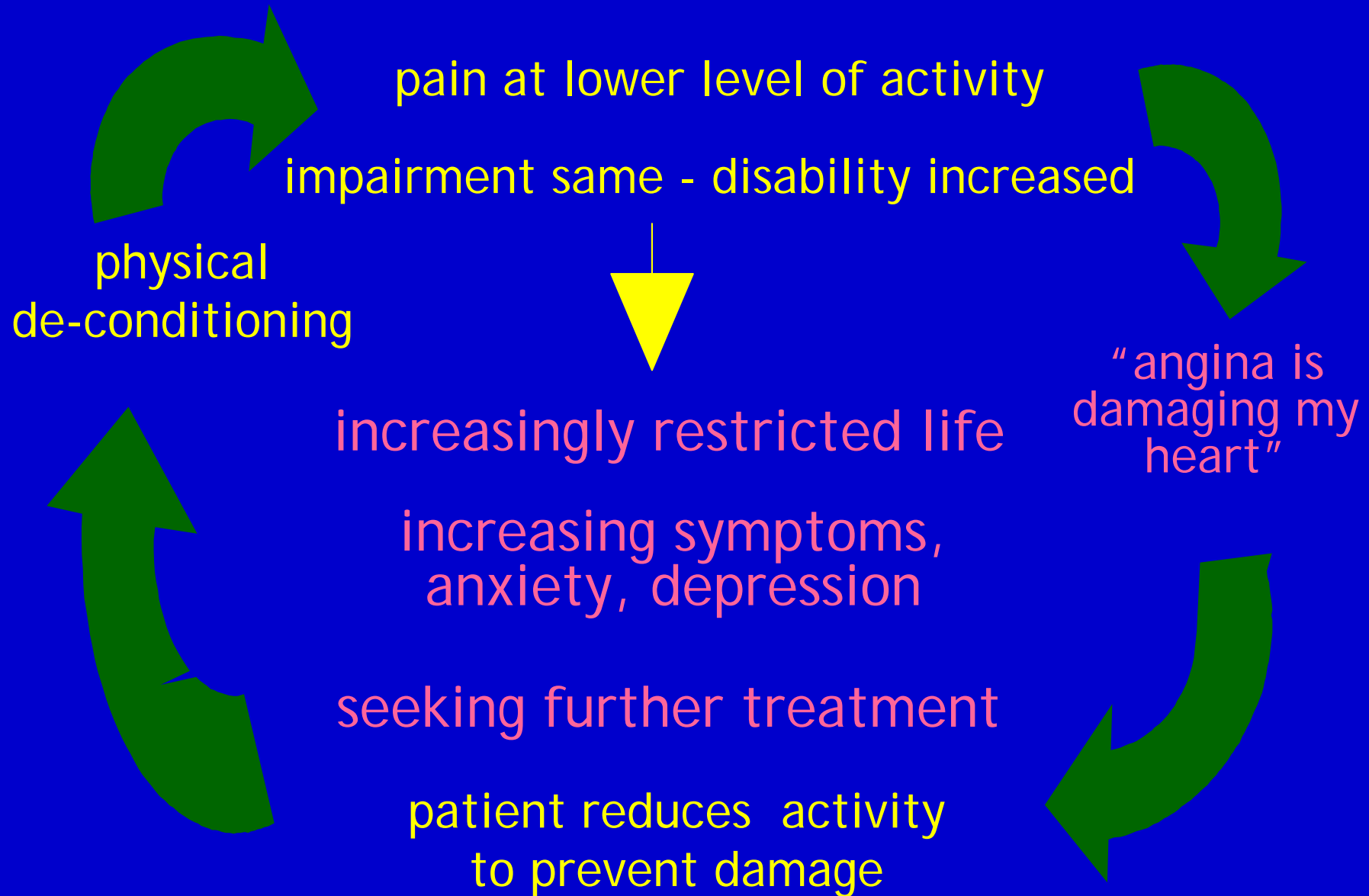
It's a good idea to check to see how you feel before deciding what to do 80%

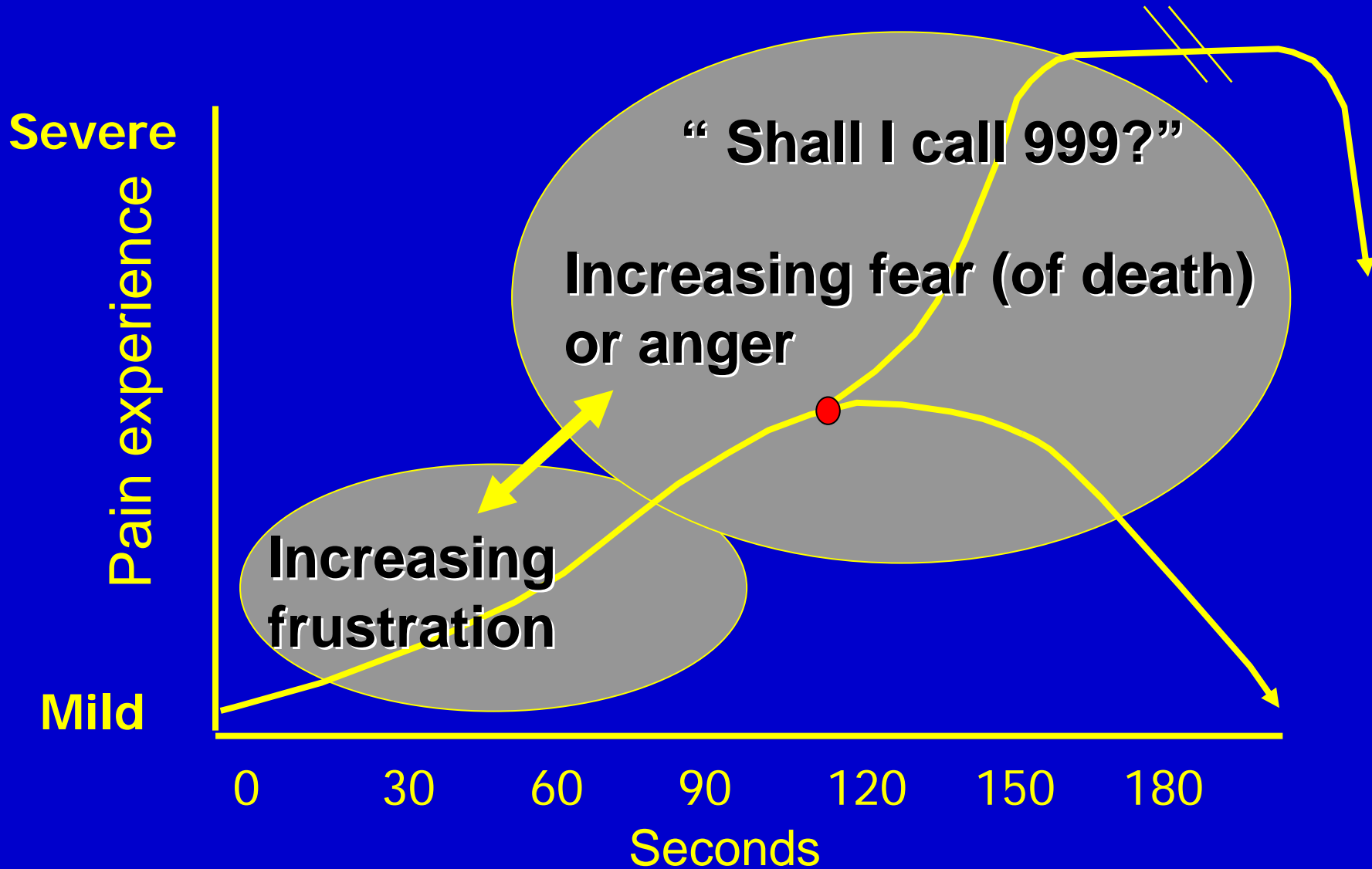


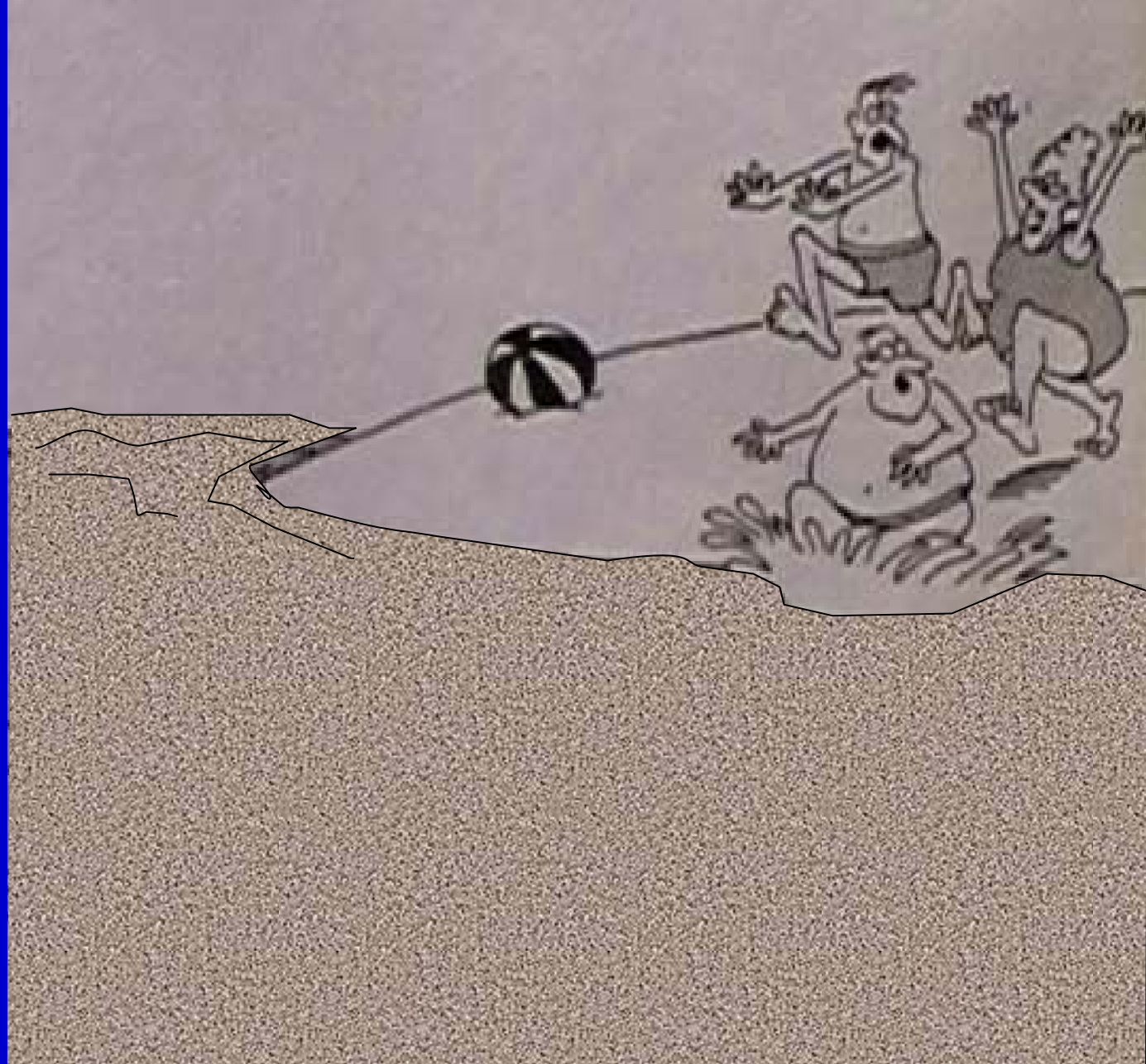
angina

Heberden 1768
"Angor Animi"

The role of –ve health beliefs in disability

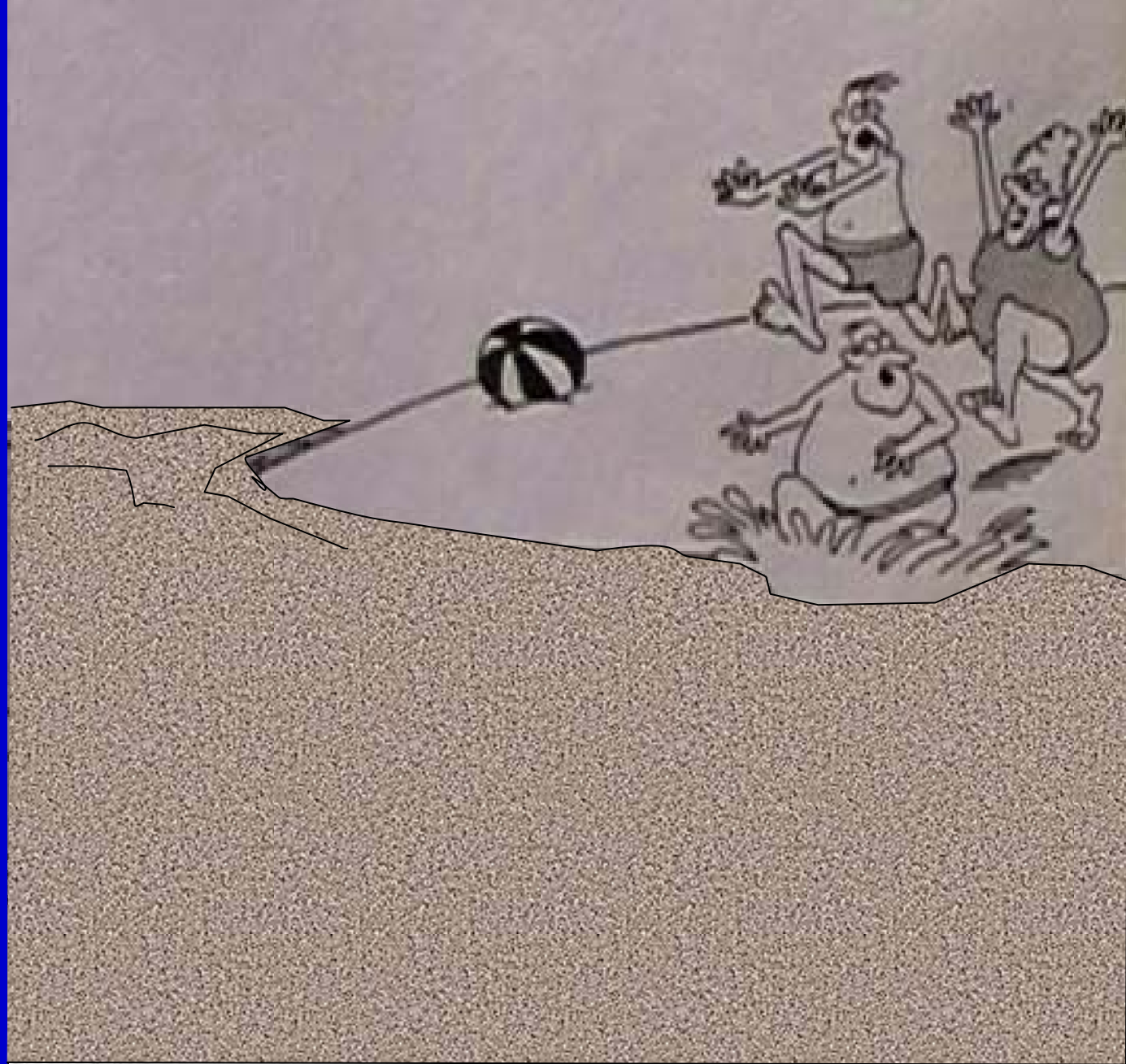






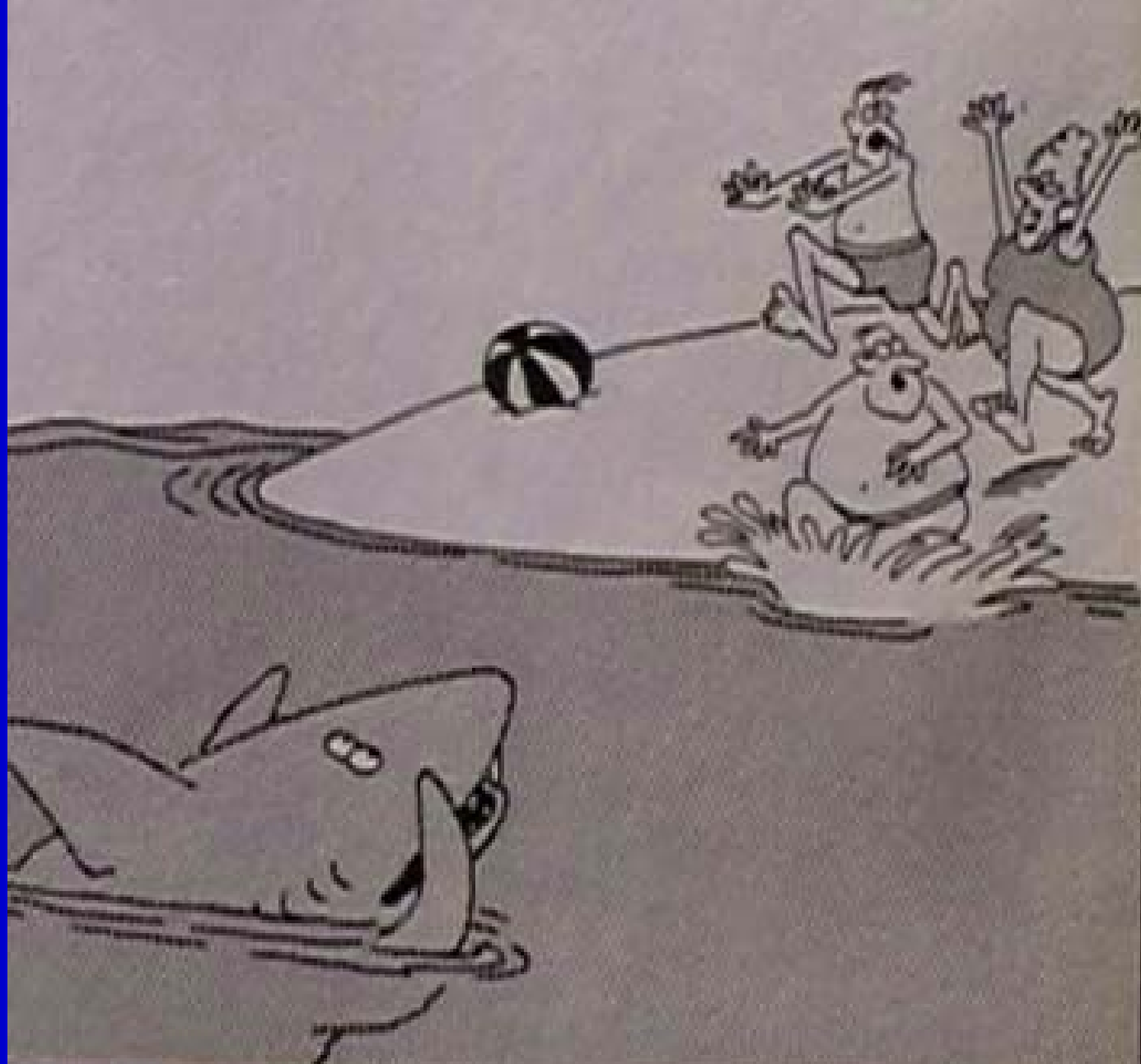
“Bomb! Bomb!”

**The
poorly
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“Bomb! Bomb!”

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“Bomb! Bomb!”

European Society of Cardiology stable angina management guidelines *Eur Heart J 1997;18:394-413*

Psychological factors.

“While the role of stress in the genesis of coronary artery disease is controversial, there is no doubt that psychological factors are important in provoking attacks of angina.

Furthermore, the diagnosis of angina often leads to excessive anxiety. Reasonable reassurance is essential, and patients may benefit from relaxation techniques and other methods of stress control. Appropriate programmes may reduce the need for drugs and surgery”

Coneybeare's textbook of Medicine 5th edⁿ

(p552, Livingstone, Edinburgh 1940)

- 'There is always the possibility of sudden death in the next attack'
- 'It is important to recommend a regime which excludes as far as possible such factors as predispose to an attack'
- 'Any exercise, mental strain or overindulgence of any kind should be forbidden'
- 'To the patients friends it is probably wise to be frank as to the possibility of a fatal attack at any time'

ESC on treatment of angina

ESC stable angina management guidelines *Eur Heart J* 1997;18:394-413

General management (p10)

“Patients and their close associates should be informed of the nature of angina pectoris, and the implications of the diagnosis and the treatments that may be recommended.”

ESC on treatment of angina

ESC stable angina management guidelines *Eur Heart J* 1997;18:394-413

General management (p10)

“The patient can be reassured that, in most cases, angina improves with proper management.”

ACC/AHA/ACP-ASIM Stable Angina Guidelines

Gibbons et al Circ 1999; 99: 2829-2848

Updated November 2002 freely available on www.acc.org

- **“Because the presentation of ischemic heart disease is often dramatic and because of impressive recent technological advances, healthcare providers tend to focus on diagnostic and therapeutic interventions, often overlooking critically important aspects of high quality care. Chief among these neglected areas is the education of patients”**

Angina and Quality of life at one year post Brief CB-CDMP *(Moore R et al . Eur J Pain. 2005 Jun;9(3):305-10)*

	Improvement	p (wilcoxon)
● Angina stability	33%	.03
● Angina frequency	30%	.02
● QoL	35%	.001

All patients rated 'CBT' as "extremely worthwhile"

The majority (86%) of patients were satisfied with their progress and did not want to try invasive therapies

ESC on treatment of angina

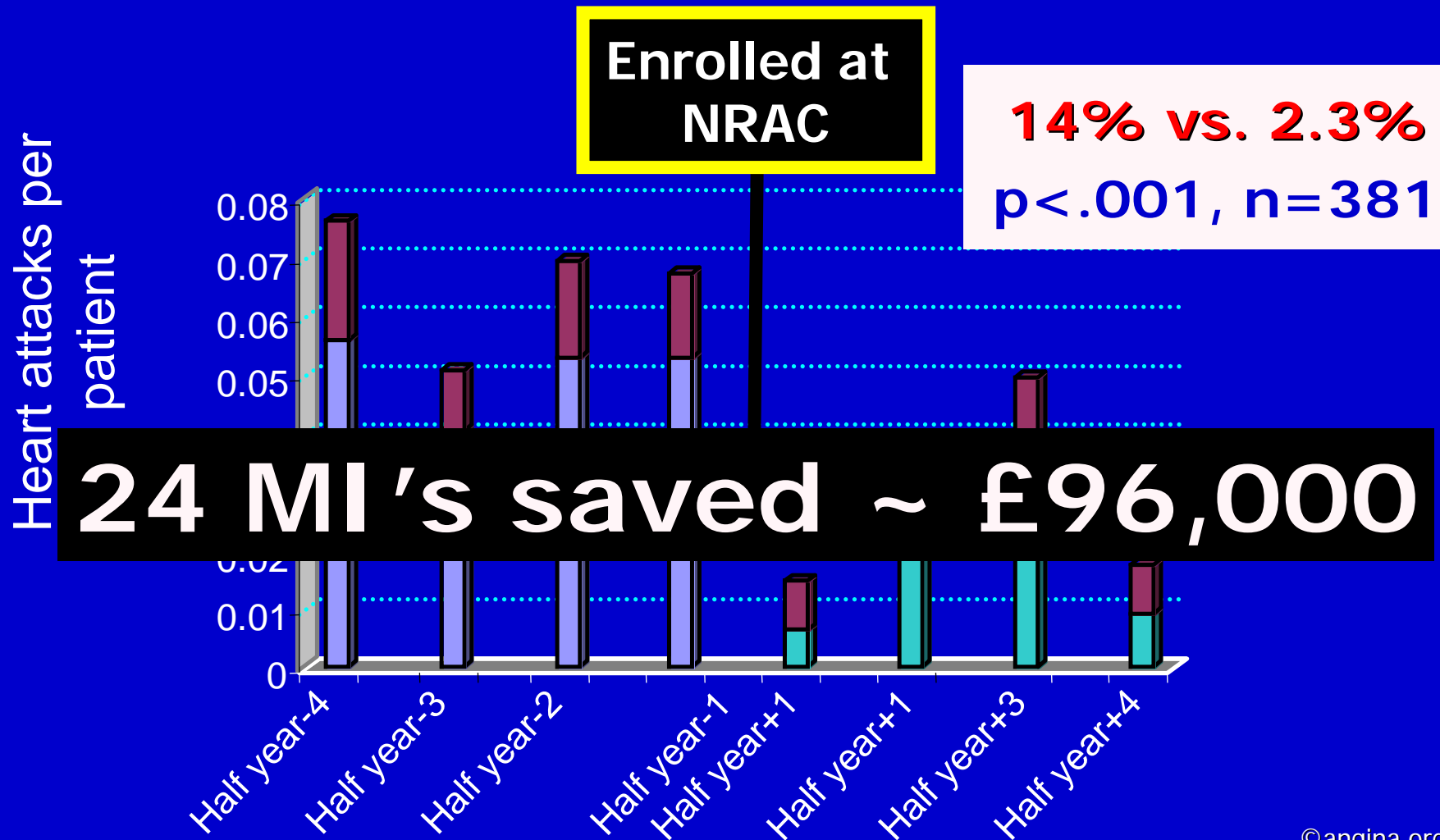
ESC stable angina management guidelines *Eur Heart J* 1997;18:394-413

General management (p10)

“Risk factors, especially smoking habit and lipid levels, should be assessed in all cases. Particular attention must be paid to elements of the lifestyle that could have contributed to the condition and which may influence prognosis.”

MIs before & after enrolment in NRAC with 95% upper confidence interval

In press J Pain & Symptom management



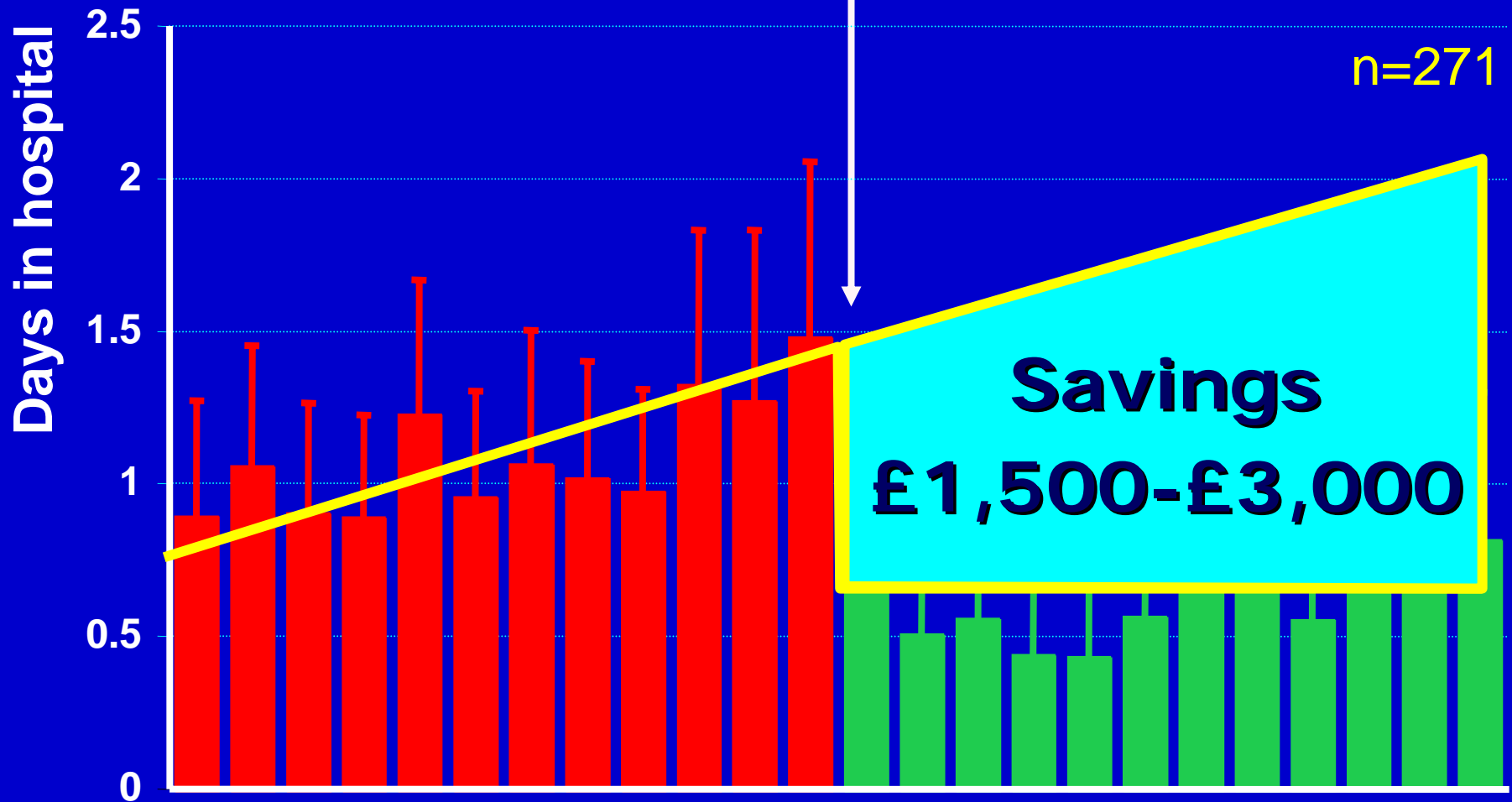
Effect of NRAC's brief CB-CDMP on admissions a year pre and post enrolment

	Pre	Post	% Reduction	p value
Admissions	651	483	-26	<0.001
Days in hospital	4196	2802*	-33	<0.001
Cardiac days	3501	2120	-39	<0.001
MI days	282	79	-72	0.007
Other days	601	590	-2	0.311

@*£260 day⁻¹ £1,543.00 per patient = £418,200 total

*Pre 2007/8 tariff estimate

Monthly Cardiac Days In Hospital before ■ and after ■ enrolment in NRAC

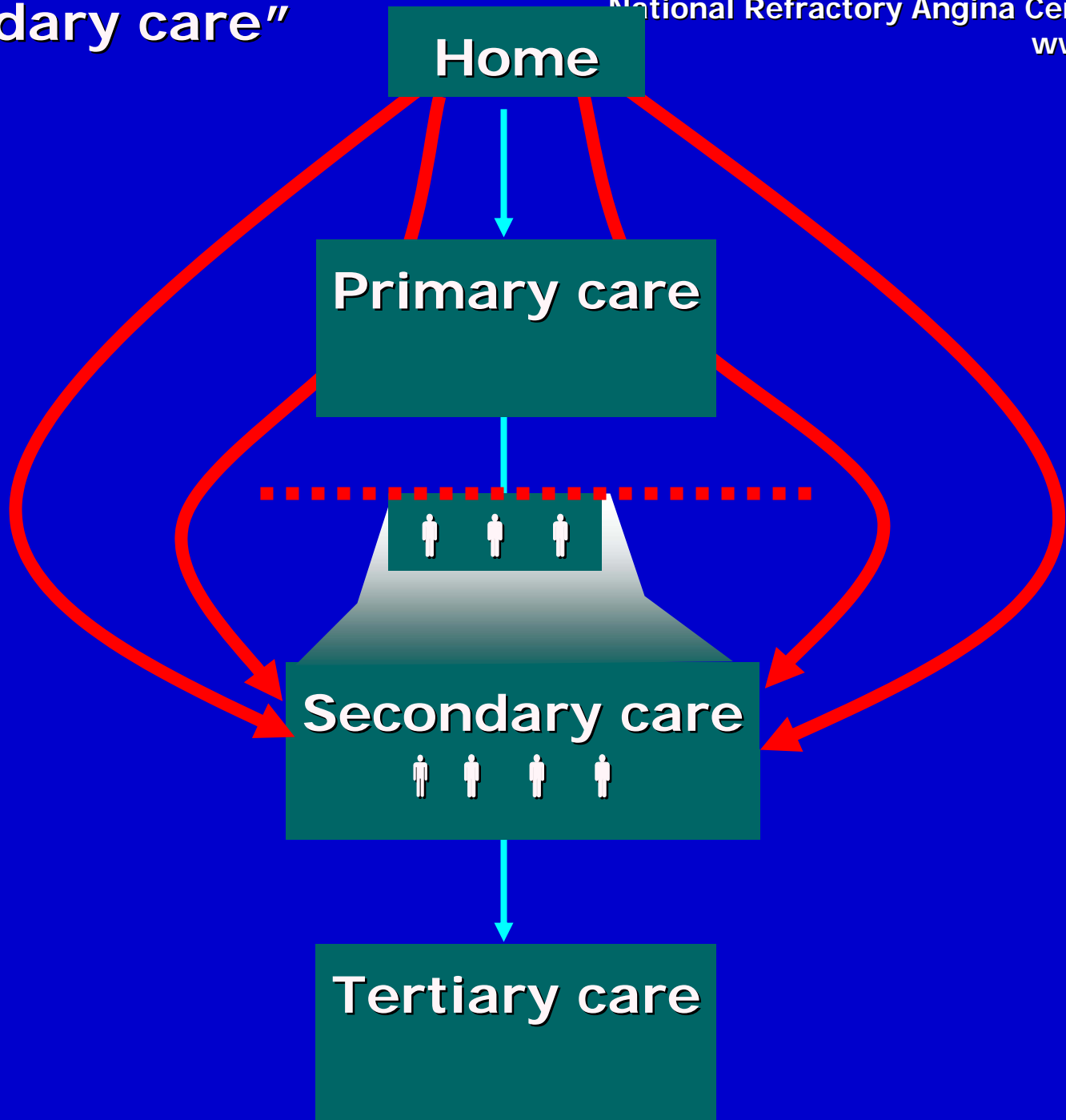


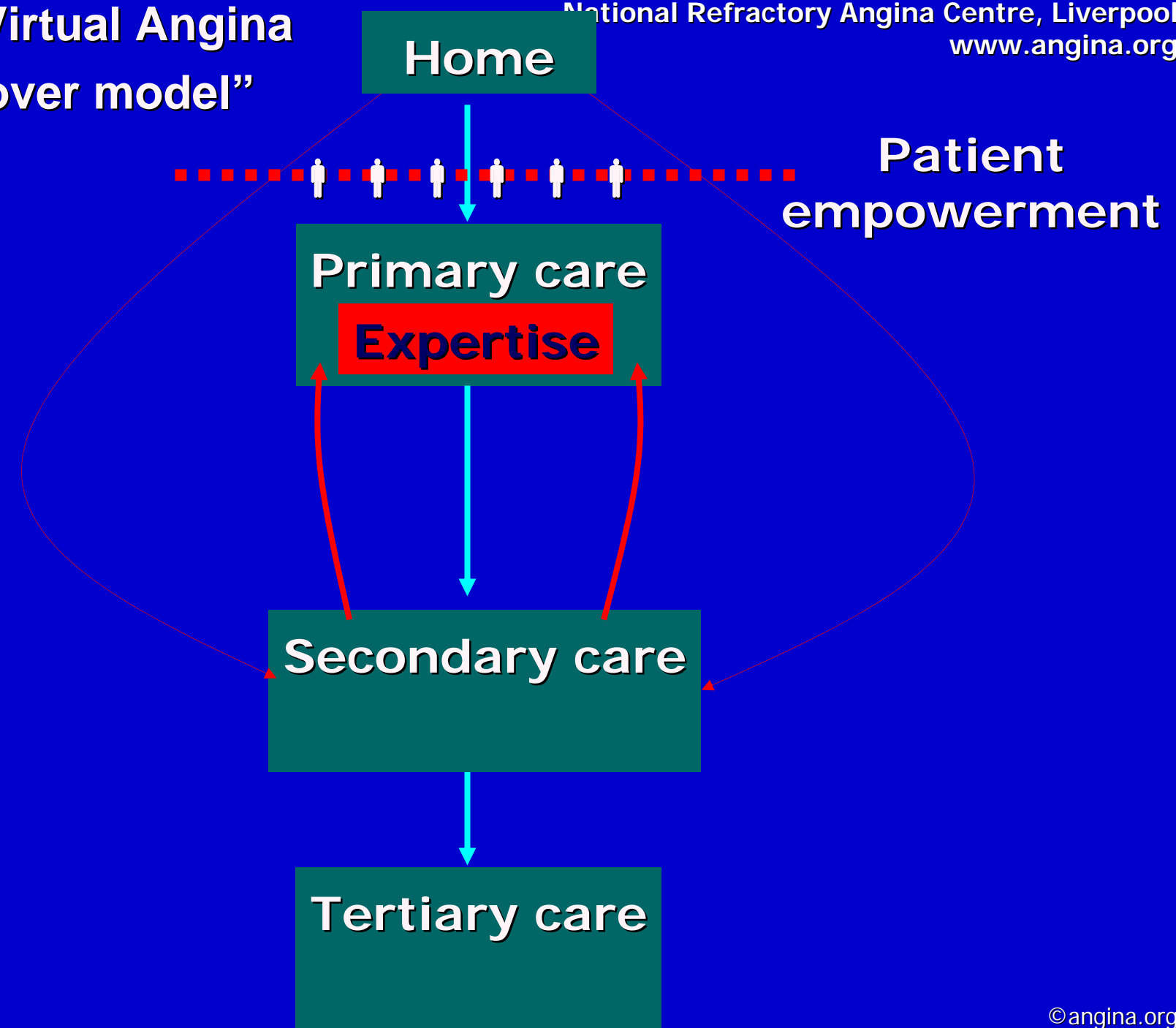
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"Secondary care" model





The AHA on education for angina

“In summary, patient education requires a substantial time investment by **primary-care** providers and specialists using an organized and thoughtful approach”

“The potential rewards for patients are also substantial in terms of improved quality of life, satisfaction, and adherence to medical therapy”

“As a result, many should also have improved physical function and survival”

ACC/AHA/ACP–ASIM Stable Angina Guidelines *Gibbons et al Circ 1999; 99: 2829-2848*

“Appropriate (CBT) programmes may
reduce the need for drugs and
surgery”

ESC stable angina management guidelines *Eur Heart J 1997;18:394-413*

Angina Management Programme: 1st trial

Crossover - waiting list to treatment - 82 patients

Main findings at 1 year after treatment;

- 30% no angina
- 70% reduction in episodes of angina
- 57% improvement in exercise duration
- 72% reduction in self reported disability (SIP)
- 50% of patients taken off CABG list

Annual savings ready reckoner SMR 1.0

Practice Group Size 30,000

angina pts 1,000

annual admissions cost £70,000

annual admissions saving £28,000

Revascularisation saving

20 CABG (£142,000) £71,000

25 PTCA (£79,000) £60,000

TOTAL £159,000

- **PBR is coming**
- **There is no plan B**
- **Momentum building**
- **It will hurt secondary care**
- **The trick is to be open minded to the possibility that service redesign will enhance care**