immediately after surgery. It could be an integral part of existing ERAS programs and dovetail well with other ERAS elements. Patient education is a key component of both this program and ERAS and is associated with improvements in anxiety, pain, and postoperative nausea management.⁸ Conceivably, such initiatives could also have a positive impact on the ongoing opioid crisis.

The amount of time, effort, and resources required to set up and implement this program cannot be underestimated. The authors, and the wider team, should be congratulated on their efforts. This is a great example of a pragmatic quality-improvement initiative with clinically meaningful outcomes.

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Commentary: House calls, phone calls, or FaceTime! Postdischarge outcomes are improved by education and follow-up

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The issue of postdischarge outcomes in patients undergoing thoracic surgery is an important topic that garnered even more attention after The Hospital Readmissions Reduction Program in 2012 government standards were set in place regarding readmission rates and linking payment to the quality of hospital care and reducing payments for excess readmissions.¹

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CENTRAL MESSAGE

Whether it is in person or via telehealth, postdischarge education and follow-up are essential in improving length of stay as well as postoperative outcomes and readmissions.

In this article, the authors evaluate the impact of an in-house program they developed, Integrated Comprehensive Care (ICC; integrated patient-centered, hospital-based multidisciplinary community program) on postdischarge

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Disclosures: Dr Soukiasian is a speaker for Medtronic and proctor for Intuitive Surgery. The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Received for publication May 20, 2020; accepted for publication May 21, 2020; available ahead of print June 7, 2020.

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J Thorac Cardiovasc Surg 2021;162:332-3

0022-5223/\$36.00

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<http://dx.doi.org/10.1016/j.jtcvs.2020.05.090>

outcomes in their patients undergoing thoracic surgery compared with their previous routine care.² This program is composed of a nurse coordinator, 12 nurses with thoracic specialty training as well as 10 physiotherapists, 4 occupational therapists, 10 personal support workers, 3 dietitians, 2 speech language pathologists, and 1 social worker, in addition to a 24-hour hotline for patients to contact an ICC nurse with thoracic training who can provide education, support, or further medical guidance for the patients when necessary. The program is associated with a cost of approximately \$175,000. Although it would be wonderful to devote these kinds of resources to the outpatient follow-up of postoperative patients, the cost and number of people who make up this team is rather large and may not be feasibly reproducible across most institutions.

A study published in 2016 used a simple 8-item preadmission questionnaire (which included patient self-reported health) as a predictive early discharge risk assessment tool.³ The authors found this questionnaire to be predictive of readmission and length of stay for elective cases. As such, the use of a questionnaire in advance of elective admissions could help in resource allocation for discharge planning, such as the need for home health or telehealth follow-ups. In addition, studies have demonstrated that telephone follow-up can help with postdischarge outcomes and has been shown to result in fewer hospital readmissions and emergency department visits for patients receiving these telehealth and telephone interventions, led by advanced practice nurses.⁴ These sort of telehealth options may be more feasible and more easily implemented across institutions as compared with a program requiring a lot of human resources.

The authors have performed extensive propensity matching; however, it is not always possible to eliminate all confounders. For example, despite propensity score matching, the minimally invasive surgery (MIS) rate is 42.1% in the ICC group versus 30.7% in controls, and the pneumonectomy rate is 1.9% in ICC versus 4.4% in control. In addition, within the control group, there were twice the number of open cases versus MIS cases. This study combines both thoracotomy and MIS into one for outcomes. It is unknown

whether the MIS fraction of the total is contributing to the improved outcomes or is it the intervention of the ICC program itself. One may consider, is it possible that the shorter length of stay in ICC is related to the increased MIS approach and its associated ERAS (ie, Enhanced Recovery After Surgery) implications of improved outcomes⁵?

In this current state of coronavirus disease 2019 (COVID-19) and the increased adoption of telemedicine and telehealth, the findings of this study as well as other similar postoperative outcome-improvement studies may affect future practices of surgical providers who decide to implement these suggestions, but via virtual visits either by video or phone, as has been demonstrated to be effective by Antonoff and colleagues,⁶ rather than having a physical visit at home by a nurse.

I find this study shows the importance of a team approach, with focus on coordinated care postdischarge, to help reduce adverse outcomes and readmissions. It provides a good model for programs looking to incorporate postdischarge care and helps reaffirm the importance of the team approach and follow-up as well as access to resources by patients postdischarge.

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