Commentary: Integrated comprehensive postdischarge care: More than just readmission avoidance

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Lung-resection surgery is not without risk, and approximately one third of patients will have a postoperative complication. Following discharge, a sizeable proportion of patients will go on to attend their local emergency department, and many will be readmitted to hospital with delayed events such as pulmonary complications, surgical-site infection, or venous thromboembolism. Unplanned readmission is not just a blip in a patient’s recovery. It is associated with increased costs and worse outcomes, including a reduction in short- and long-term survival.1

What factors are associated with readmission? We know that an initial postoperative complication is strongly associated with a subsequent unplanned readmission.2 There have also been concerns that a drive to a shorter length of stay, often seen as a byproduct of enhanced recovery after surgery (ERAS) programs, may be a factor, but this has not been shown to be true.3,4 It seems, however, that the majority of readmissions after cancer surgery are potentially preventable.5 This suggests that the close monitoring of discharged patients, combined with the opportunity to intervene outside of the hospital setting, may improve patient outcomes. Furthermore, the financial penalties of readmission in many health care systems increase the appeal of such initiatives.

In this issue of the Journal, Ahmadi and colleagues6 describe the implementation of a novel multidisciplinary postdischarge outpatient support program for patients recovering from lung resection surgery in Canada. All inpatients undergo a needs assessment immediately after surgery and appropriate discharge planning is initiated. At the same time, patients’ expectations are managed, and they are educated about potential postoperative events. Once discharged, there are regular telephone calls and home visits. Ongoing nursing care, such as dressing changes and oxygen therapy, is coordinated centrally. Other allied health needs, such as physiotherapy and occupational therapy, are also managed within this integrated care program. Importantly, a 24-hour hotline is available. Home visits (within a few hours) or outpatient surgical clinic appointments (next day) can be arranged if necessary.

The program’s effectiveness has been evaluated by comparing 2 cohorts of patients, before and after implementation. The results are impressive, with significant reductions in visits to the emergency department, down from 28.4% to 9.8%. There were reductions in readmissions, as well as improvements in length of hospital stay and even short-term survival.6 The authors have previously demonstrated its cost-effectiveness.6 It will be interesting to see whether these beneficial effects can be reproduced in other health care systems.

Looking forward, it would make sense to initiate a postdischarge program in the preoperative clinic rather than...
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. 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.

References