Commentary: Oh the places you’ll go? Implications of cardiac rehab following surgery

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This study of Medicare patients undergoing cardiac surgery examines utilization of cardiac rehab and its association with discharge location in a large population of patients undergoing coronary artery bypass grafting and/or aortic valve replacement.1 One-third of patients were discharged to an extended care facility (ECFs). Cardiac rehab utilization was significantly (20%) less in these patients, even after risk-adjustment. The crux is that cardiac rehab enrollment and participation was associated with a reduction in 1-year mortality (ECF: 15.8% reduction and home: 3.6% reduction) and in readmissions (ECFs: 16.5% reduction and home: 7.7% reduction), and these results were amplified in ECF patients.1

Cardiothoracic surgeons have developed significant initiatives and data collection for other interventions that improve the lifespan and quality of life for patients undergoing cardiac surgery, yet participation in cardiac rehab has not traditionally been tracked or even officially endorsed.

Cardiac rehab is more than simply monitored exercises; rather, it allows for counseling and intervention for medication compliance, reduction of risk factors (like smoking cessation and diet modification), and intangible but important social components of shared experiences between patients that may influence postoperative depression.

With competing interests and requirements during training, education as to what actually occurs at inpatient and outpatient cardiac rehab is substantially lacking in residency programs. This may lead to practicing surgeons being less enthusiastic and/or knowledgeable toward considering advocating for their patients to enroll in these programs and/or to champion a program of their own at their institution.

Bauer and colleagues1 examined patients undergoing coronary and/or aortic valve procedures; however, other patient populations may also benefit. For example, many patients undergoing isolated aortic surgery through a sternotomy are excluded from participation in cardiac rehab due to nuances in technical definitions that allow insurance companies to deny involvement. Thus the influence of this study may perhaps be larger.

Within our specialty, many quality metrics have been implemented and improved outcomes, such as use of arterial graft(s), management of concomitant atrial fibrillation, prescription of beta-blockers perioperatively, and prevention of surgical site infection. With the influence of these new data in mind, how can surgeons and educators best advocate for patient participation in cardiac rehabilitation postoperatively? We should also consider whether or not our specialty should consider tracking this metric as an outcome indicator within our database.

Conflict of Interest Statement
Dr Merritt is a consultant for Atricure.

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