Why is Ambulatory Surgery Flourishing in the USA

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COI Disclosures

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None

Why is Ambulatory Surgery Flourishing in the USA?

System Factors

Facilities for Surgery in the USA

Ownership primarily private-sector, not government

Hospitals:

- Most hospitals in USA treat mix of private and public patients.
- All-government hospitals {city} do similar % AS.

Hospital Outpatient (HOP)

Freestanding Ambulatory surgery centers (ASC)

Office-Based Surgery (OBS)

USA: “Ambulatory Surgery”

Definition:

The patient goes home
at the end of the working day
< no overnight stay >

In USA,

No extra payment for overnight stay

No ‘patient hotels’

1960s Hospital-Based Surgery Units: International Response to Long Surgical Wait Lists

Webb, Graves Vancouver 1959

Cohen, Dillon UCLA California 1962

Levy, Coakley GWU Washington,DC 1966

93% AS pt again; 95% recommend to others

Calnan, Martin Hammersmith: Quonset hut 1967

Reduced plastic surgery waitlist by 50%

Save cost of hospital bed Reduced OR cost

Growth of Ambulatory Surgery 1970s & 1980s:

- Improved anesthesia drugs & surgical technology
- Patient demand for convenience and satisfaction
- Satisfying and convenient surgical experience
- Crowded hospitals with waitlists for surgery.

Phoenix SC (1970) sought active support from local hospitals, planning agencies, major insurers:

- Private insurers embrace AS

Cost Incentives for growth, later ...

Payment as Enabler of Change: Government

1980 Medicare [for elderly] & Medicaid [for poor] programs added provisions for ambulatory surgery:

Established list of appropriate procedures

If surgeons perform listed procedures as ambulatory, will be reimbursed 100% charges, vs 80% if IP.

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Diagnosis-related groups (DRG)

➔ 40% reduction in Medicare IP days by 1988

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2000 Medicare PPS for hospital Outpatient services:

Ambulatory Payment Classification Groups (APCs) prospective payment system.

2008 Medicare ASCs join APC PPS.

Surgical Procedures in the US

BWH 1980	1981	1986	1991	1996	2001	2006
#Procs (million)	19.7	22.2	26.5	32.1	38.6	50.2
Hosp IP, %	80	56	41	31	24	16
HospOP	18	36	44	44	45	45
FASC	1	5	10	15	17	18
Office	1	3	5	10	14	20
TOTAL OP %	20	44	59	59	76	83

National Center for Health Statistics: 1996 & 2006

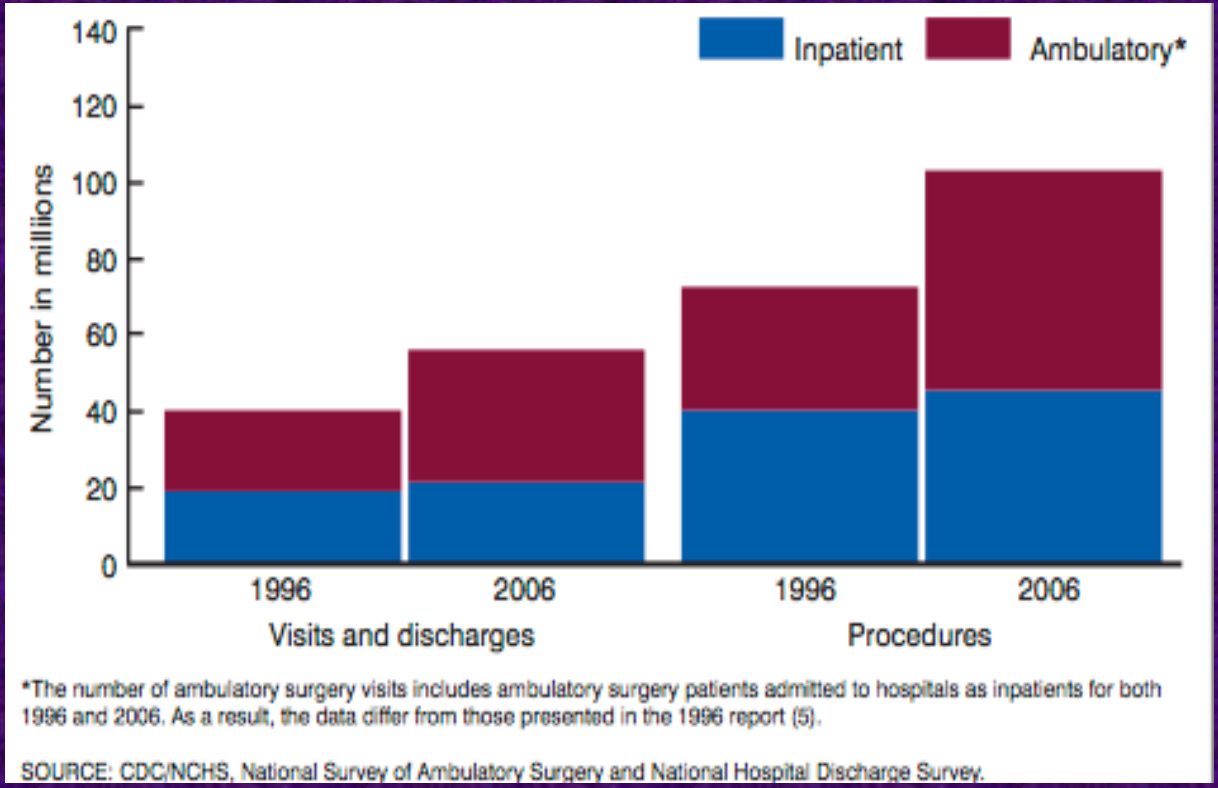
National Survey of Ambulatory Surgery

Medicare principal payer

Visits and Procedures: 1996 v. 2006

Ambulatory Surgery v. Inpatients

Visits
2006:
34.7
million



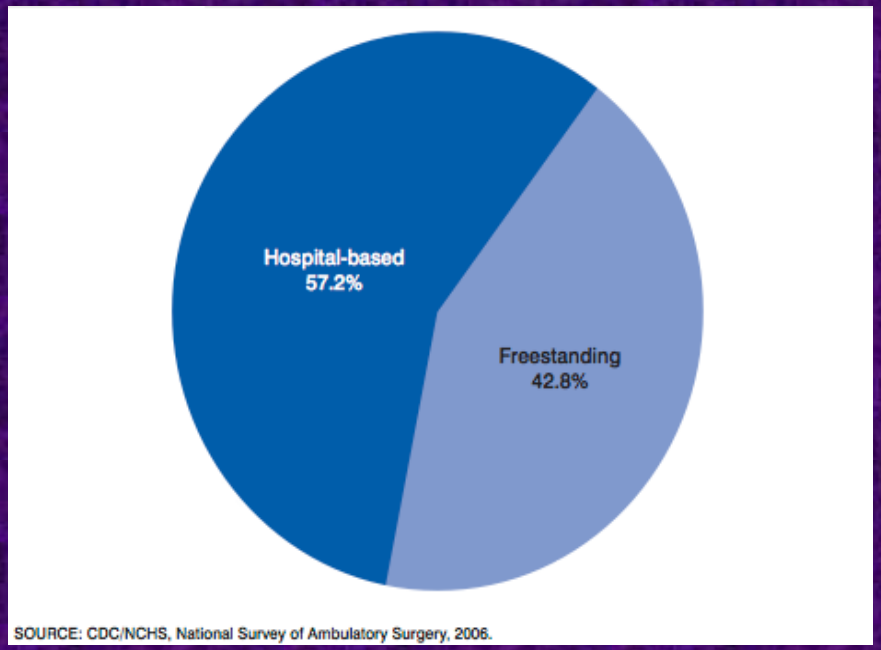
Proc
2006:
57.1
Million
=
61.6%

National Survey of Ambulatory Surgery 2006

Distribution Medicare Ambulatory Surgery visits by Type of Facility

57.1 Million

57.2%
Hosp all



42.8%
FASC

Why is Ambulatory Surgery Flourishing in the USA?

Care Process Factors

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Patient Evaluation

WHO?
Patient Evaluation - Medical

PAST	Healthy	ASA I and II
NOW	Stable	ASA III, plus
	- Not Chronologic Age	

How Should We Decide:

- What Would be Gained by Preop Admission?
- Can Patient Return to His/Her Baseline by End of Day?

Patient Evaluation - Psychosocial

PAST Willing to Participate in Periop Care
Reliable to Follow Instructions
Home Situation Adequate

NOW Act to Improve:
Address by patient & family education,
social services planning

Who are NOT Appropriate AS Patients?

Site Specific – Identify the acceptable patients for skills & equipment of <u>your</u> facility and personnel.

In general, No:

** Active substance / alcohol intoxication

** Significant psychosocial problems

** Unstable ASA PS III or IV

Morbid obesity ±

Sleep apnea ±

Malignant hyperthermia ±

Appropriate Patient Selection

Combination of Patient & Procedure Factors

Healthy Patient - Intrusive Procedure

Marginal Patient - Minimal Procedure

Avoid Routine Preoperative Testing

Routine Testing: NO

testing if no history or physical findings

Indicated Testing: YES

indicated by patient state or surgical procedure

: pt's medical diseases (DM, renal, pulmonary)

: risk of surgical blood loss

Will the Result Change the Anesthesia Plan ?

Cardiovascular Evaluation of AS Patient: Functional Capacity METs

Mets	Activity
1	Eating, getting dressed, working at a desk
2	Showering, walking down 8 steps
3	Walking slowly on a flat surface for 1-2 blocks
4	Raking leaves, washing dishes, light house work
5	**Walking 4 miles in 1 hr, social dancing, climbing 1-2 flight of stairs, walk uphill**
6	9 holes of golf carrying clubs, heavy carpentry, using a push mower

4-5 METs: equiv to physiologic stress of most noncardiac surgery under GA

PreAnesthesia Evaluation
Needed for All Patients-

WHEN?

All Patients Should be Medically Optimal Before Day of Surgery

Very few Surgeons: Do medical workup themselves.

Most Surgeons: Send pt to personal physician.

Some Surgeons: Send pt to anesthesiology clinic with agreement to do medical evaluation.

Preanesth eval not correct time to screen for disease.

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CAN BE excellent time to OPTIMIZE pt's medical issues

ASA "Perioperative Surgical Home"

Option for the Healthy Patient : Evaluation with No Prior Visit

* Not Day-of-Surgery evaluation *

Health questionnaire by patient:

paper; computer; web

Telephone health survey plus education ,

by Unit nurses (recovery)

If any positives, refer to Anesthesiologist

Timing of PreAnesthesia Evaluation
Pros & Cons – Different Costs

Separate Visit evaluation:

PRO	Chance to solve issues
	Avoid late cancellations
CON	Personnel cost

Day of Surgery evaluation:

PRO	More convenient for patient
CON	OR time cost
	Risk of late cancellations

The Pre-Anesthesia Clinic

For Not-Healthy Patients &
Option for Healthy Patients

Good Approach
Especially when AS program starting or growing
(While surgeon's offices learn new processes)

Economical for Hospital: Useful for both
Ambulatory Patients
and
Same-Day Admission InPatients

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Care Process Factors

Patient Education

To Make our Patients Ready for AS, Give Information, not only Get Information: Patient Education

What do patients want to know?

Educational needs

What do patients need to know?

Informational needs

A Major Reason for

Ambulatory Surgery Success in USA

What Do Patients Want to Know?
Minor Side Effects are Common

1, 511 responders = 41 % Follow-up postcard

86 % ≥ 1 Symptom After Discharge

62 %	Drowsiness	25 %	Headache
49 %	Sore Throat	20 %	Dizziness
47 %	Aches	17 %	Nausea
		7 %	Vomiting

Return to Normal Activity? 2-3 days

Philip BK. J Clin Anesth 1992;4:355-8.

What Should Patients Know?

What do patients want to know?

What do patients need to know?
Informational needs

Preop Fasting Recommendations :
Patients without Risk, All Ages
Unlimited Amounts

Ingested Material	Minimum Fasting Period
Clear Liquids *	2 hr
Breast Milk	4 hr
Light solids, nonhuman milk/ formulae	6 hr

Water, black coffee or tea, pulp-free juice, carbonated beverages

1999 ASA Practice Guidelines for Preoperative Fasting

Preoperative Policies

When to Arrive

What to Wear and Bring

Continue Routine Medications

Specific Medical Care:
Insulin-Dependent Diabetics

Must have Adult Escort Home

AMBULATORY SURGERY UNIT - GENERAL DISCHARGE INSTRUCTIONS

FOR YOUR OWN SAFETY AND WELL-BEING,

For the first 24 hrs after your operation, you should:

1. **NOT** DRIVE an automobile
2. **NOT** DRINK any alcoholic beverages
3. **NOT** make any important DECISIONS

Please follow all of your surgeon's discharge instructions.

Give patient: Ambulatory Surgery telephone

Emergency Service telephone

Surgeon's telephone

Ambulatory Surgery Unit : Procedure - Specific Discharge Instructions

- Surgical
  - Developed by Nursing-Surgeon collaboration
  - Procedural issues (bleeding, voiding)
  - Postdischarge medication instructions (pain)
- Anesthetic
  - Spinal ; Regional Blocks
  - Postdischarge medication instructions (PONV, Transderm Scop)

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Incentives

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