Why is Ambulatory Surgery Flourishing in the USA

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Beverly K. Philip, M.D.

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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   Diagnosis-related groups (DRG)
   -> 40% reduction in Medicare IP days by 1988

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

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>#Procs (million)</td>
<td>19.7</td>
<td>22.2</td>
<td>26.5</td>
<td>32.1</td>
<td>38.6</td>
<td>50.2</td>
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<tr>
<td>Hosp IP, %</td>
<td>80</td>
<td>56</td>
<td>41</td>
<td>31</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td>HospOP</td>
<td>18</td>
<td>36</td>
<td>44</td>
<td>44</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>FASC</td>
<td>1</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Office</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>10</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>TOTAL OP %</td>
<td>20</td>
<td>44</td>
<td>59</td>
<td>59</td>
<td>76</td>
<td>83</td>
</tr>
</tbody>
</table>
Visits 2006: 34.7 million

Proc 2006: 57.1 Million

= 61.6%

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

*The number of ambulatory surgery visits includes ambulatory surgery patients admitted to hospitals as inpatients for both 1996 and 2006. As a result, the data differ from those presented in the 1996 report (5).
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

SOURCE: CDC/NCHS, National Survey of Ambulatory Surgery, 2006
Why is Ambulatory Surgery Flourishing in the USA?

Care Process Factors
Why is Ambulatory Surgery Flourishing in the USA?

Care Process Factors

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

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.
All Patients Should be Medically Optimal
Before Day of Surgery

Very few Surgeons: Do medical workup themselves.
Some Surgeons: Send pt to personal physician.
Most Surgeons: Send pt to anesthesiology clinic.

Preanesth eval not correct time to screen for disease.
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
Why is Ambulatory Surgery Flourishing in the USA?

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
49% Sore Throat
47% Aches

25% Headache
20% Dizziness
17% Nausea
7% Vomiting

Return to Normal Activity? 2-3 days

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*

<table>
<thead>
<tr>
<th>Ingested Material</th>
<th>Minimum Fasting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear Liquids *</td>
<td>2 hr</td>
</tr>
<tr>
<td>Breast Milk</td>
<td>4 hr</td>
</tr>
<tr>
<td>Light solids, nonhuman milk/ formulae</td>
<td>6 hr</td>
</tr>
<tr>
<td>Water, black coffee or tea, pulp-free juice, carbonated beverages</td>
<td></td>
</tr>
</tbody>
</table>

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
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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System Factors – Incentives
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System Factors
  Incentives
  Care Process Factors
    Patient
    Evaluation
    Patient Education