



Keeping you active.

Home Same Day is Safe

Chancellor F. Gray, MD

September 21, 2024



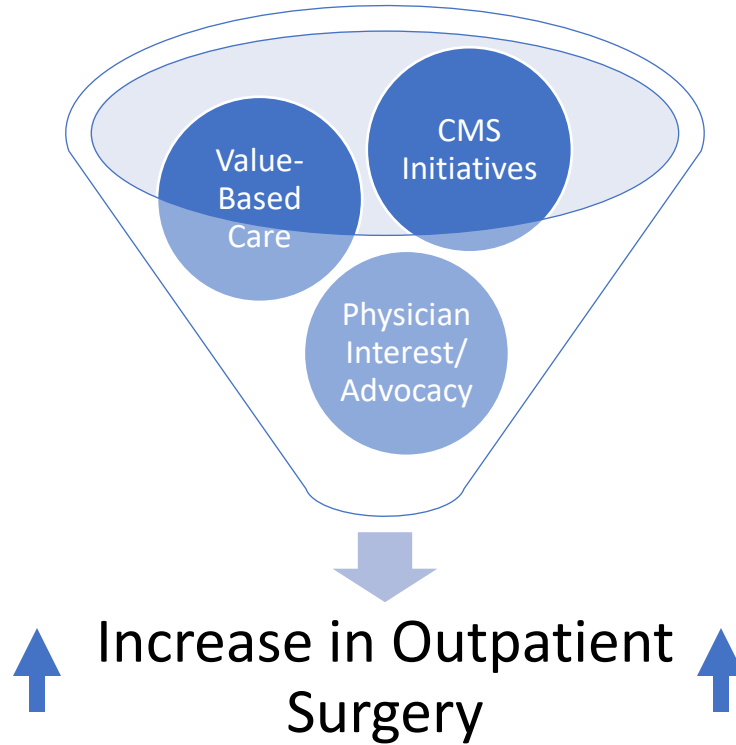
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The Evolution of Outpatient Arthroplasty





ELSEVIER

Right-Sizing Care: The Growing Role for Ambulatory Surgery Center-Based Total Knee Arthroplasty



Atul F. Kamath,[†] Jeremy Statton,^{*} and Charles DeCook^{*}

<https://doi.org/10.1016/j.oto.2021.100904>

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Step 1: Create an Outpatient Program

Key Needs (necessary and sufficient)

- Capable/ engaged surgeon(s)
 - Predictable and consistent surgical times ($\leq \sim 90$ minutes—not including take off and landing)
 - EBLs within range (200-500mL)
- Capable/ engaged anesthesiologists
- Nursing/PT
 - Either one works well- we no longer use PT in our two ASCs
- Engaged patient & caregiver
 - +/- home nursing/PT
- Facility that is aligned

Facility Alignment

Contents lists available at ScienceDirect

Arthroplasty Today

journal homepage: <http://www.arthroplastytoday.org/>



Original research

Outpatient total knee arthroplasty: is it economically feasible in the hospital setting?

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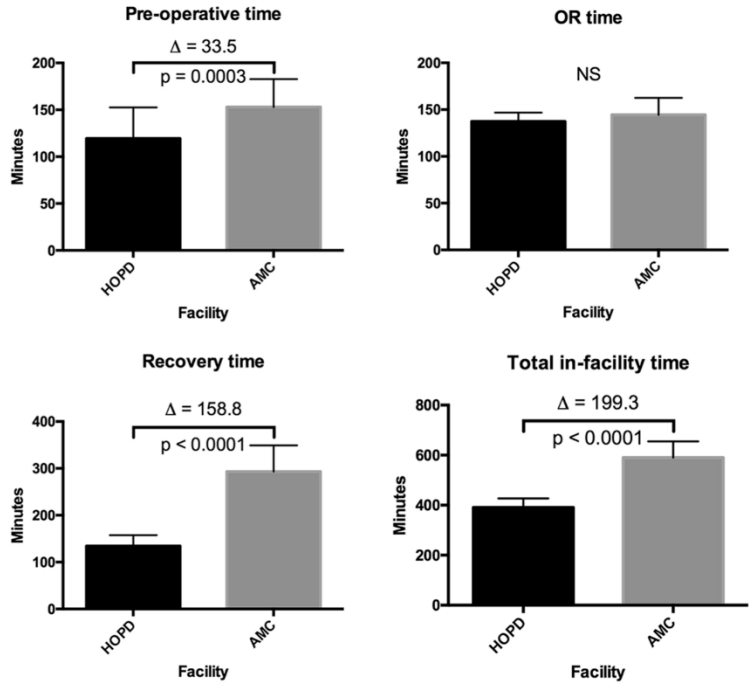


Figure 1. Time analysis comparing the 2 sites of care. The HOPD was more efficient in all phases of care except for the time in the actual operating room. NS, nonsignificant.

Step 2: Spread the Messaging



Step 3: Choose Patients Wisely

Table 1

Inclusion criteria for outpatient protocol.

Surgical factors	Medical factors	Social factors
Primary THA or TKA First/second case of the day	Age < 75 y BMI < 35 No anemia, COPD, CHF No cirrhosis No VTE history No spinal stenosis No BPH No chronic narcotics Surgeon discretion	RAPT > 10 Proximity to hospital Private insurance

Transition to outpatient total hip and knee arthroplasty: experience at an academic tertiary care center

Hrishikesh C. Gogineni, MD ^{a,*}, Chancellor F. Gray, MD ^a, Hernan A. Prieto, MD ^a, Justin T. Deen, MD ^a, Andre P. Boezaart, MD, PhD ^{a,b}, Hari K. Parvataneni, MD ^a

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^b Department of Anesthesiology, University of Florida, Gainesville, FL, USA

Step 3: Choose Patients Wisely

Table 1

Inclusion criteria for outpatient protocol.

Surgical factors	Medical factors	Social factors
Primary THA or TKA	Age < 75 y	RAPT > 8
First/second case of the day	BMI < 35	Proximity to hospital
	No anemia, COPD, CHF	Private insurance
	No cirrhosis	
	No VTE history	
	No spinal stenosis	
	No BPH	
	No chronic narcotics	
	Surgeon discretion	
	Patient desire/ motivation	

Transition to outpatient total hip and knee arthroplasty: experience at an academic tertiary care center

Hrishikesh C. Gogineni, MD ^{a,*}, Chancellor F. Gray, MD ^a, Hernan A. Prieto, MD ^a, Justin T. Deen, MD ^a, Andre P. Boezaart, MD, PhD ^{a,b}, Hari K. Parvataneni, MD ^a

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What if Patient is Reluctant?

“I’d just feel safer in the hospital/
staying one night”

“But will I be able to get around the
house all right?”

“What if something happens?”

“The hospital is a good place to get sick”

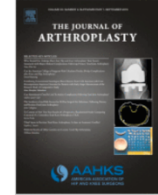
“Yes! With your walker, and you’ll almost
certainly feel better that day/ next day/
going forward than you do right now”

“Thankfully, complications are
exceedingly rare. But... when things
happen, they typically happen once
you’re home either way, and we will be
calling to check in regularly”

Who Should Not Undergo Short Stay Hip and Knee Arthroplasty? Risk Factors Associated With Major Medical Complications Following Primary Total Joint Arthroplasty

[P. Maxwell Courtney, MD](#) · [Joshua C. Rozell, MD](#) · [Christopher M. Melnic, MD](#) · [Gwo-Chin Lee, MD](#) 

[Affiliations & Notes](#)  [Article Info](#) 



Results

Of the 1012 consecutive primary THA and TKA patients included in the study, 70 patients (6.9%) experienced a perioperative complication during their index hospital admission. Fifty-nine (84%) of these complications happened after 24 hours post-operatively. The mean age was 60.3 years (range 17–89 years) while the mean body mass index (BMI) was 32.7 kg/m² (range 15–63 kg/m²). There were 21 grade II complications, 24 grade III complications, and 14 grade IV complications. The most common of these complications were cardiac in 15 patients (25%) followed by pulmonary in 13 patients (22%) and neurologic in 10 patients (17%). Descriptive statistics of the data set are listed in [Table 1](#).

Outcomes after First Year

- Success rate: 85% (currently > 95%)

- Failure causes:

Orthostatic hypotension

Urinary retention

Nausea

Dense Peripheral Nerve block (improved since transition to ACB and short acting spinal)

Pain

	Outpatients (n = 105)	Inpatients (n = 136)	P value
Age (years, mean)	57.3	53.9	.08
Body mass index (kg/m ² , mean)	30.03	30.55	.46
Length of stay (days, mean)	0.24	1.53	<.01
Readmission rate	0.95%	3.70%	.18
Complication rate	1.90%	2.90%	.61

Your Rapport with the Patient is Essential

If I was going to have surgery, or my family was going to have surgery, this is, unquestionably, what I would want for myself or them

Other Strategies to Address Patient Hesitance

2017 KNEE SOCIETY PROCEEDINGS

Preoperative Physical Therapy Education Reduces Time to Meet Functional Milestones After Total Joint Arthroplasty

Soeters, Rupali PT, MEd, PhD; White, Peter B. BA; Murray-Weir, Mary PT, MBA; Koltsov, Jayme C. B. PhD; Alexiades, Michael M. MD; Ranawat, Amar S. MD on behalf of the Hip and Knee Surgeons Writing Committee

[Author Information](#) 

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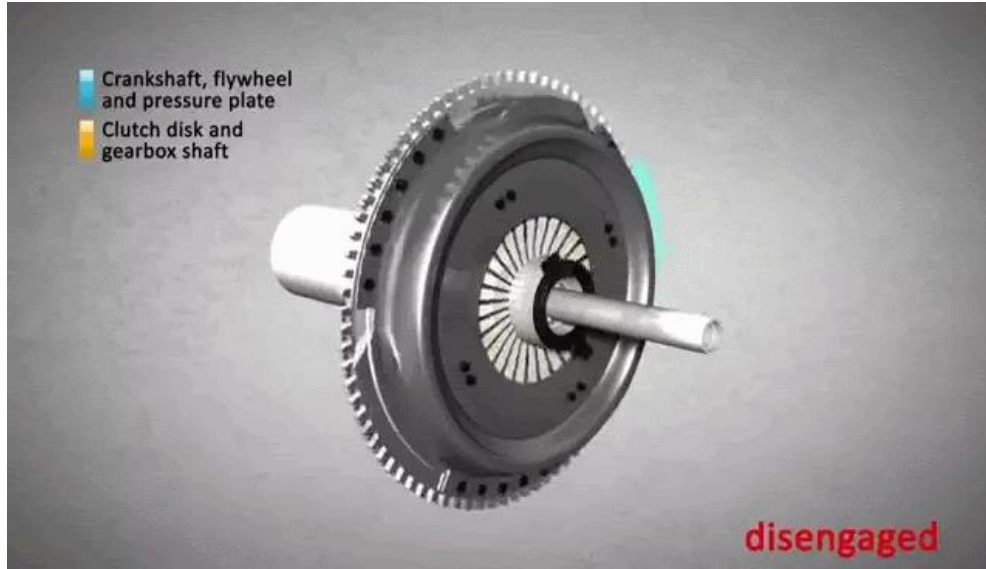
Step 4: Burn Your Boats

Transition cases to an outpatient center as soon as possible

- Gets buy-in
- Aligns parties
- Motivates patients
- Stress tests your system

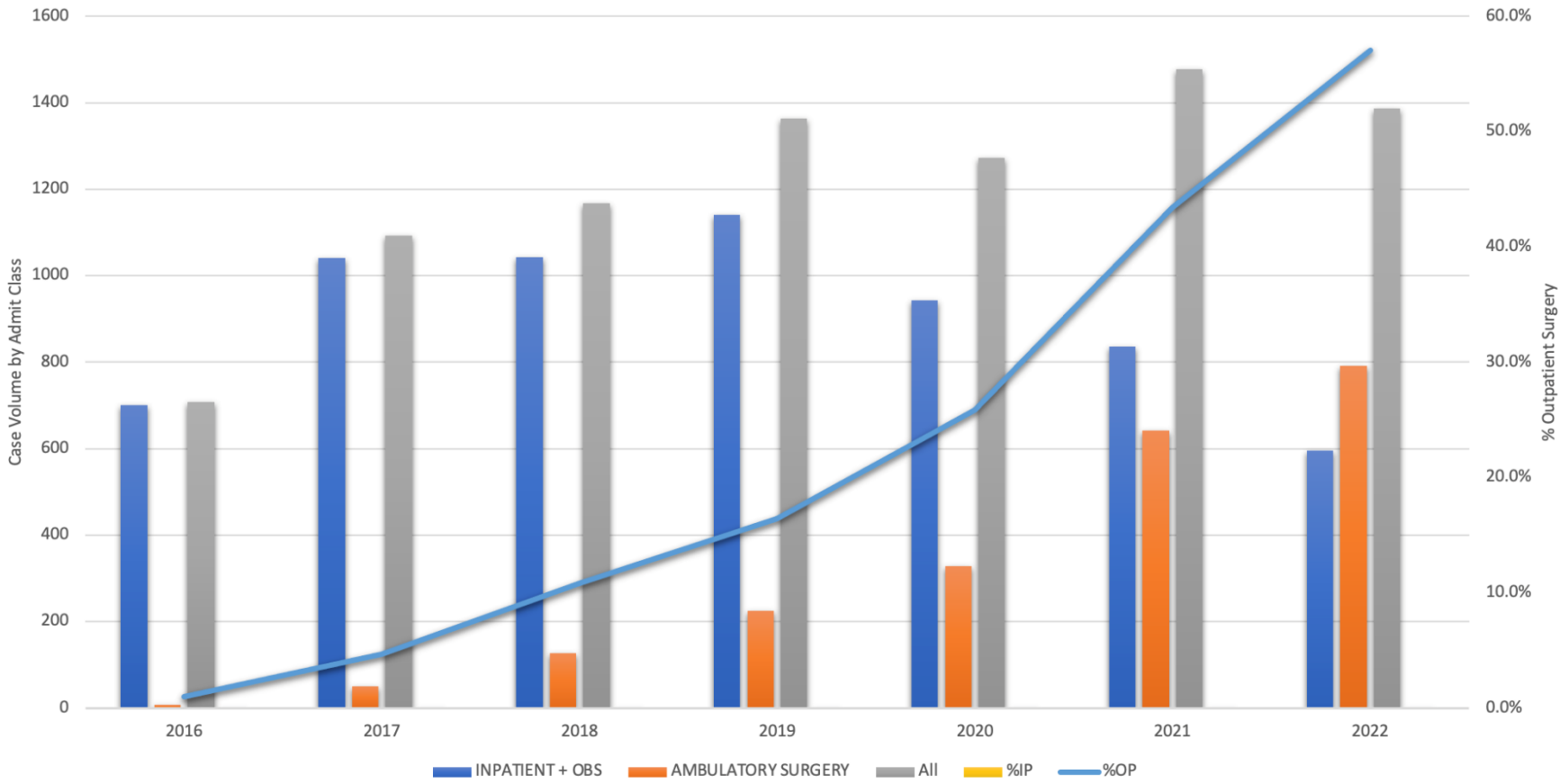


Start the Flywheel Spinning

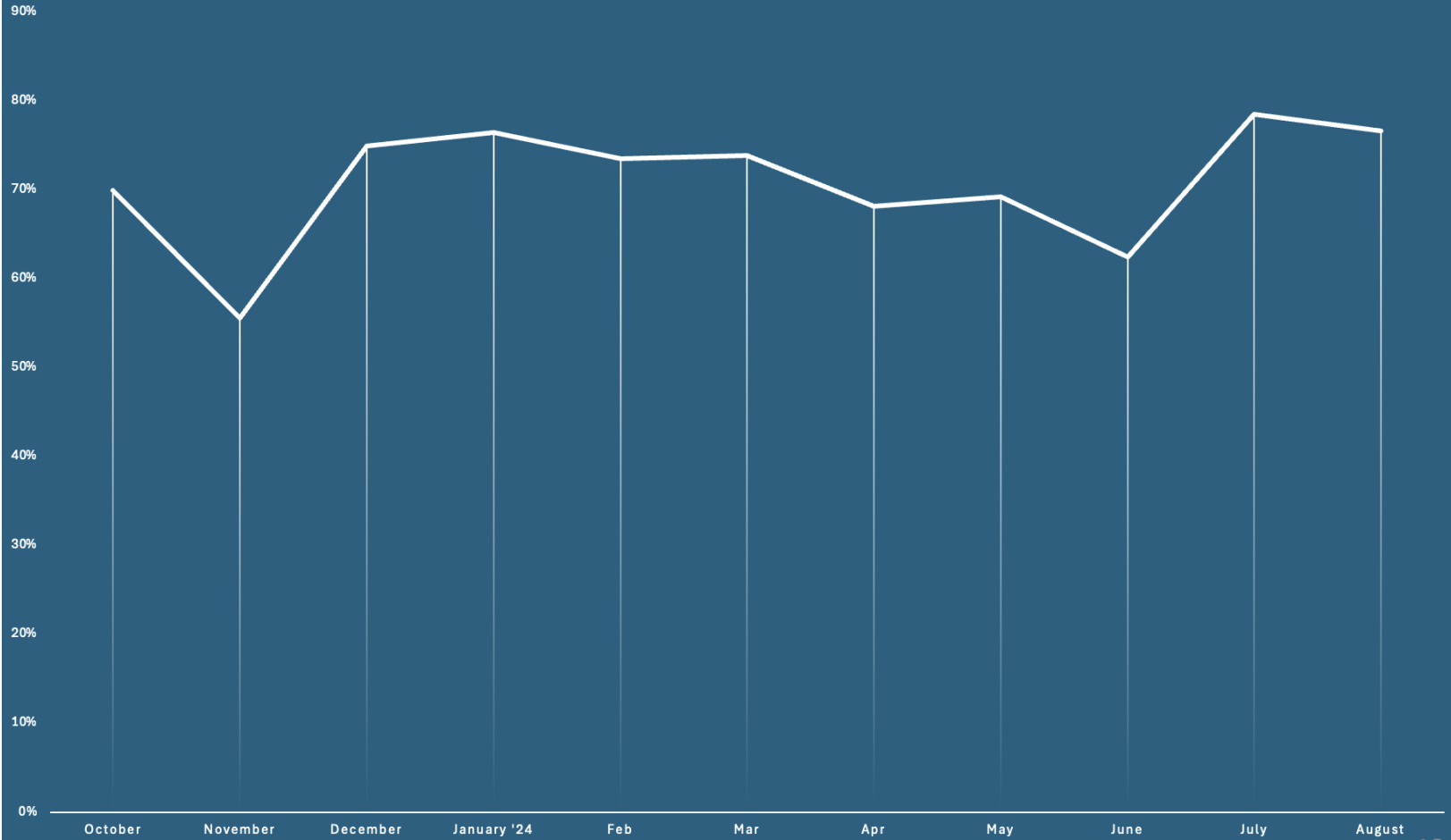


- Ok to start small/ highly selectively
- Success begets success
- Makes for easy and consistent messaging
- Becomes the standard

Primary TJA Admission Class by FY 2016-2022



OUTPT %



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Thank you!