California Orthopaedic Association

Recommended Patient-Selection Criteria for Total Joint Procedures Performed in an Ambulatory Surgical Center (ASC)

Outpatient total joint replacements are being safely performed in ambulatory surgical centers (ASCs) nationwide. Group health payors are driving this movement looking at alternates for improved patient outcomes and cost savings having surgeries performed in outpatient facilities. Surgeons are also driving this movement as they understand that properly selected patients are good candidates to have total joint replacements performed in an outpatient setting. In ASCs surgeons can be more efficient in scheduling and managing the patient, reduce infection rates, and improve outcomes by controlling the patient's recovery. Nursing ratios for post-op care are also higher in ASCs - more similar to ICU care. Medicare recognized the potential for improving patient care and cost savings by initially removing total knee replacements from the in-patient only list for hospital out-patient departments (HOPD) and is considering removing total hip replacements from the in-patient only list, as well.

Patient-selection criteria and very careful pre and post-operative preparation and planning is key to the success of these patients.

COA has developed the following patient-selection criteria for our members to consider when deciding which patients are appropriate candidates to have their joint replacement surgery performed in an ASC setting. The criteria are intended to establish exclusionary guidelines for the surgeon to consider when evaluating their patient. We recognize that every patient is different and the ultimate decision whether the patient is a good candidate to have their surgery performed in an ASC setting, should be the surgeon's decision, taking the patient's entire medical and social history into consideration.

Patient Selection

The patient must meet all of the selection criteria:

1) Be in good health
   Minimum requirements should consist of BMI 40 or less, Hgb >12, Alb> 3.4 (if lab obtained), HbA1c <7.5 (if indicated), Platelets >150, minimal or no renal disease, minimal controlled COPD, and limited vascular disease.
2) No patient history of hypercoagulability
3) No uncontrolled history of congestive heart failure or oxygen dependent pulmonary disease. Cardiac clearance suggested with stents and questionable arrhythmias.
4) No moderate or severe sleep apnea.
5) No history of cirrhosis.
6) No history of esophageal varices.

7) Patients with an ASA classification of I or II. Patients with an ASA classification of III should be decided on a case-by-case basis.
8) Cooperative and able to understand and follow instructions.
9) Have good social support – a spouse, friend, or sibling who can attend the pre-operative preparatory education and will accompany the patient home for the first 3-4 days. This individual must be readily available. This supporting person will need to accompany the patient to their physical therapy and post-operative appointments as needed until the patient is independently mobile.

Exclusion Criteria in addition to the above criteria:

1) Multiple coexisting cardiac or pulmonary problems that are poorly controlled (hypertension or angina).
2) Significant lymphedema.
3) Previous total joint Infection, an incompletely treated skin or wound infection, or an active respiratory infection.
4) Transplant patients who are not otherwise healthy.
5) Non-ambulatory patients.
6) Neuromuscular disorders (stroke with deficits on the operative side, Parkinson, CP, post-polio).
7) Pregnant patients.
8) AICD or pacemaker dependent patients.
9) Patients with known or family history of malignant hyperthermia unless results of a negative MH diagnostic test are available.
10) Severe aortic stenosis, severe pulmonary hypertension, hypertrophic cardiomyopathy, or previous Tetralogy of Fallot.
11) Likely to require a transfusion of blood products.
12) Renal failure patients (medical conditions that are commonly connected with difficult airway such as Pierre-Robin, Treacher-Collins, Goldenhar's Syndrome, and Epidermolysis Bullosa).

Surgical Preparation

Preparation will be more exhaustive than the inpatient total joint arthroplasty in that the patient needs to be more emotionally prepared. The patient must understand the procedure, the problems that can occur, post-operative care, and a full understanding of what is expected from the patient

It is critical the support person and patient have a clear understanding of the procedure and the post-operative instructions and each agree to participate fully.

Post-Operative Care

Pre-operative and post-surgical exercises can be done at home and do not always require a physical therapist. The therapist is there to guide and motivate the patient. The therapist must also have a clear understanding of what the surgeon expects of the patient the milestones that are to be achieved.

Execution of the Procedure

1) Execution of the procedure requires a team that is familiar with the surgeon and well-educated in total joint arthroplasty.
2) Anesthesia – preferably should be regional and include a periarticular injection
3) Pain medication – pre-operatively arranged.

4) Adequate use of fluids pre-operatively, intra-operatively and, to some extent post-operatively
5) Best Practice – perform these procedures early in the day whenever possible, so that the post-surgical rehabilitation can be started on the same day.
6) Patient will need to be discharged from the surgical ASC within 24 hours. The patient could be discharged to home or they may need to go to a Recovery Care Center, often an accredited ASC, whose focus is on post-surgical pain management, for a second 24-hour stay.
7) The ASC must be accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) or the Joint Commission (formerly JCAHO).
8) The ASC must have an arrangement with an acute care facility to deal with emergent care.
9) The patient must be able to get in and out of bed, walk independently, be able to take nutrition and have post-op nausea controlled before discharge.
10) Post-operative communication with the patient is important. -The surgeon, patient and the supporting individual must be available by telephone.

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