Ambulatory surgery: The future is now

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Ambulatory surgery is not only the thrust of the future, it is the thrust of today. Today approximately 25% of all surgeries performed nationwide are ambulatory; by 1990 predictions indicate an increase to 50%. Regardless of program model, administrative and physician cooperation will be necessary for a facility to maintain its share of this outpatient marketplace. Anesthesia plays a vital role in any successful ambulatory surgery program. Management, marketing, and planning will insure the quality of an ambulatory program; anesthesia, surgeon, and staff cooperation will insure its success.

Currently, four models of ambulatory surgery programs exist: integrated, separated, satellite and freestanding. The first three are usually hospital affiliated, while the freestanding facility is oftentimes physician owned and managed.

In the integrated model, the hospital establishes a formal ambulatory surgery program incorporating it into the existing inpatient surgical program. This model uses existing inpatient operating rooms, admitting, pre- and post-operative areas.

The separated model is a facility within the hospital or on the grounds of the hospital, usually connected by a tunnel, bridge or other structure. It is especially constructed for ambulatory surgery.

Satellite facilities are completely separate ambulatory centers (similar to freestanding) located some distance from the hospital, but under the auspices of the hospital.

The fourth setting is an independently-operated freestanding ambulatory surgical center. Freestanding facilities have generally been owned and managed by physicians, but increasingly, there are trends toward ownership by profit-oriented hospital and health care corporate chains.

Integrated model

Advantages. The advantages of the integrated program are that it can be established readily, requires little capital investment with minimal additional staff, and utilizes hospital services. Specialty consults are readily available. It is relatively easy to admit the patient if necessary, and there is capability of extensive surgery if, for example, a positive biopsy is diagnosed. Also, the unit can be dismantled quickly if the program is not working.

Disadvantages. The disadvantages of the hospital integrated program include: patient mixing in pre- and post-operative areas, (each of which requires very different procedures and care), the possibility of “bumping” outpatient surgical procedures from the surgical schedule, the fact that extensive inpatient charting systems (forms and records not applicable to an outpatient setting) are more the rule than the exception, and the fact that all patients are subject to the inpatient pricing schedule. Operating room nurses and other personnel are accustomed to inpatient procedures and heavily sedated patients. The possibility exists that ambulatory surgery patients may be looked upon as “second class” patients.

Separated model

Advantages. There are several advantages of the hospital separated program. First, it is a tailor-made program. This seems to invoke greater satisfaction from the patient, family, and staff. It is separate from the main operating rooms and thus can maintain its own efficient schedule. The staff is trained in the special procedures accompanying
ambulatory care, and is accustomed to dealing with healthy, alert patients and their families. Should there be a need, hospital services and equipment can be utilized and specialty consults are available. Admittance into the hospital is quick and simple—waiting time is minimal.

Disadvantages. The disadvantages of the hospital separated system are few. Frequently the pricing schedules reflect the inpatient charge-levels, and extensive inpatient charting, as mentioned previously, is not streamlined to reflect the needs of the outpatient setting.

**Satellite model**

**Advantages.** The hospital satellite program advantages are: it is tailor made; there is greater satisfaction on the part of the patient, family and staff (patient and family are not lost in the hospital system, are not mixed with sick inpatients, and receive care and caring directed toward the well outpatient); and physicians can retain their affiliation and sense of identity with their own hospital when utilizing the satellite facility of another institution. In addition, the staff is trained to manage only the outpatient.

**Disadvantages.** The facility is hospital owned and managed, and this may be reflected in the pricing. Specialty consults are not readily available, nor is there capability for sharing equipment. Admitting patients to a hospital, should it become necessary, is not as convenient as in the integrated and separated models. Physicians utilizing the satellite facility experience a loss in flexibility and convenience traveling between hospital and satellite facility—particularly when the facility moves any distance from the hospital campus.

**Freestanding model**

**Advantages.** The freestanding facility has similar advantages to the satellite program. There is less red tape due to a smaller superstructure and generally lower pricing compared to the other three models.

**Disadvantages.** With the exception of pricing, disadvantages are similar to the satellite facility. It is absolutely necessary that a freestanding facility have a transfer agreement with one or more hospitals.

**Trends in health care delivery**

In 1980, the American Hospital Association collected the first and most comprehensive nationwide data on hospital ambulatory surgery pro-

grams. Approximately 66.4% of the hospitals in the United States provided ambulatory surgery services, and of the 19.6 million surgical procedures which took place during that year, 16.4% (3.2 million) of these were performed on ambulatory surgery patients.3

The 1983 annual survey of hospitals revealed that of those hospitals that are nonfederal, short-term stay, general hospitals, 88% do ambulatory surgery. Of the 20.8 million surgical procedures which took place during 1983, 23.9%, almost 5 million, were performed on ambulatory surgery patients.3

The trend is towards ambulatory surgery. A little more than 5 years ago, less than 15% of all surgeries in the United States were performed on an ambulatory basis. Currently, that number has risen to 25%, and by 1990, it is projected that the number will be 50%. At The Methodist Medical Center of Illinois, 51% of our 15,000 plus surgeries are performed on outpatients. Ambulatory surgery is not just the thrust of the future. It is the thrust of today, offering comparable care, cost-efficiency, and convenience to the patient, family, and physician.

The Health Care Financing Administration (HCFA) several years ago studied what the cost savings would be if a procedure could be shifted from inpatient care to: (1) a hospital ambulatory surgical facility; (2) a freestanding ambulatory surgery facility; or (3) a physician's office facility. HCFA noted a 53% savings if the patient could be moved from an inpatient hospital setting to the hospital ambulatory facility; a 63% savings if the patient could be moved to a freestanding facility, and a 73% savings if the patient could be moved to an office facility.4 Statistics generated at The Methodist Medical Center of Illinois show a cost savings of approximately 50% when patients utilize the ambulatory surgery center rather than having like procedures performed as inpatients.

In recent years, there has been a return to performing surgery in the physician's office, and this will be an area of growth in the future. A Society for Office-Based Surgery has already been established.* Office-based surgery is cost-effective and convenient to the physician, patient and family. Insurance companies have noted the cost savings, and some third party payers have established varying rates of payment for a particular procedure. They will pay 75-80% of the surgeon's fee if the surgery is performed in the hospital; up to a full fee if it is performed in an ambulatory sur-

*Society for Office-Based Surgery, P.O. Box 9494, San Diego, CA 92109.
gery facility; and an additional incentive of 10-25% more than the full surgical fee if the procedure is performed in the surgeon's office.

Blue Cross and Blue Shield of Michigan expect to save more than $70 million a year with new policies that they have set up for workers covered under group benefits at Ford and Chrysler. Under this plan, there are designated simple surgical procedures that physicians are encouraged to perform on an outpatient basis. Physicians will be provided with 125% of their normal and customary charges if they shift these designated procedures into an outpatient area, but will only be paid 75% when doing these same procedures on an inpatient basis unless there is a medical reason for admitting the patient.

As long as the government, industry, and third party payers are looking at cost-effectiveness, and as long as the pendulum continues to swing in that direction, we will continue to see efforts to shift cases from the hospital to ambulatory surgery facilities and even into physicians' offices. The concern of this author is that extra-fee incentives may cause some surgeons to become too aggressive in their selection sites for performing surgery. Is patient care in the physician's office truly comparable to that in a hospital? We in anesthesia have to maintain extreme caution as to the patients we anesthetize and the facilities in which we provide anesthesia services.

You do not want to find yourself providing anesthesia coverage in a physician office setting that is not accredited, or where there is not an adequate preventive maintenance program for the anesthesia equipment you will be using. So, what do you look for? What questions do you ask when the phone rings and Dr. Jones wants you to come to her office to provide anesthesia coverage?

The Society for Office-Based Surgery has specific recommendations as to the type of equipment that is needed when IV sedation or general anesthesia is utilized (Table I). Make sure that an accrediting agency has reviewed the office and given its "stamp of approval." Make sure the office staff is trained in cardiopulmonary resuscitation; that appropriate drugs are available; and that anesthesia equipment is under a preventive maintenance program. There is no problem with providing anesthesia services outside of a hospital operating room. However, as a note of caution, when venturing forth into a physician's office to provide anesthesia services, make certain that safety standards are comparable to those in a hospital.

When managing ambulatory surgery patients regardless of the setting, don't be lulled into a sense of false security thinking that you are administering anesthesia solely for short surgical procedures on only healthy patients. Extreme caution must be exercised when dealing with patients receiving compacted care.

At a meeting of the Illinois Society of Anesthesiologists in November, 1984, covering "Risk Management and Patient Safety," a review of 104 malpractice claims from a large insurance carrier revealed the following: nine claims were lodged by patients or families of patients who had had procedures done in an ambulatory surgery facility; six claims involved cardiac arrests; two were related to broken teeth; and one involved bleeding.

Although deaths and claims against ambulatory surgery facilities were initially minimal, it appears the future is bringing change.

There are no shortcuts when dealing with the ambulatory surgery patient. The successful ambulatory surgery program must provide stringent selection criteria, appropriate anesthesia management and practical discharge criteria that is closely followed.

To limit problems in the ambulatory surgery facility there is need for a sense of direction—a need for a Medical Director. This physician must be able to assess both surgical and anesthesia risks, deal impartially with all surgical specialties, and provide continuity of medical care until all patients have been discharged from the facility. Both the Joint Commission on Accreditation of Hospitals and the Accreditation Association for Ambulatory Health Care require that a physician examine and discharge patients from an ambulatory facility once all discharge criteria have been met.

In an ambulatory setting, patients are not recovering from their surgery, they are recovering from their anesthetic; whenever possible, an anesthesiologist should be considered for Medical Director of an ambulatory surgery facility. Anesthesia input is an essential ingredient to any successful facility: anesthesia is the watchdog of ambulatory surgery. A member of the anesthesia care team should always be part of the policy-making committee of an ambulatory surgical facility.

The rapid growth of ambulatory surgery during the early 1980s comes at a time when many of the factors that influence the delivery of health care services are changing. Some of these factors include: (1) escalating cost of health care; (2) increased supply of physicians; (3) increased supply of hospital beds; (4) competition between physicians and hospitals; and (5) a changing relationship among...
patients, physicians, health care organizations and the payers of health care services.

Physicians and hospital administrators are no longer complacent. They are each looking for their share of the marketplace.

Marketing

Today, if you work in an ambulatory surgery program, you'd better work very hard to insure its success. Within the next few years the competition for the ambulatory surgery patient will be as great as, if not greater than, the competition currently existing among hospitals, physicians, HMOs, PPOs, and other third party payers.

Producing customer satisfaction is the key to building customer demand in a growing and successful ambulatory surgery business—whether it is organized as a separate service contained within the walls of the hospital or as a privately-owned, freestanding entity, run separately from the traditional hospital business.

William Flexner, a marketing expert, has outlined four marketing components that all managers of ambulatory surgery patients need to keep in mind. These four components are: product, price, promotion and place. Of these four, product is obviously the most important, because if you do not have the right product for the right price at the right place, no amount of promotion will get people to come in and come back again. For anesthetists, this means a decent anesthestic at a competitive price in a pleasant facility, and do not forget a caring attitude. Marketing our services is not only possible, it is necessary.

What is meant by marketing outpatient services? A market consists of two or more individuals, each having something that the other wants, and each wanting something the other has. A market transaction occurs when these individuals get together and make an exchange. As long as both parties are satisfied with the transaction, each time they want to make an exchange of similar items, they will return to the marketplace and agree to transact another piece of business.

How does this affect the way we in anesthesia practice? Neither patients nor surgeons will return if they are dissatisfied with the transaction. With consumers (patients and surgeons) taking a more active role in the selection of health care services, it is important that all components of the ambulatory surgery center—the administration, anesthesia, and staff—understand what influences consumer choice.

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<th>Table I</th>
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<td>Equipment recommendations for office-based suites</td>
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<th>Anesthesia capability</th>
<th>Examples of appropriate operations</th>
<th>Equipment needed</th>
<th>Room size</th>
<th>Probable costs</th>
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<tr>
<td>Level 1: local anesthesia with light sedation</td>
<td>Myringotomy with tubes (adult) D&amp;C Bartholin cyst Small biopsy</td>
<td>Crash cart IV stand Ambu-Bag Airway tube O₂ tank with valve Suction machine Appropriate light</td>
<td>7'-10'</td>
<td>$2,000-$10,000</td>
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<tr>
<td>Level 2: local anesthesia with heavy sedation</td>
<td>Septoplasty Cosmetic surgery Minilap tubal Breast biopsy Open laparoscopy</td>
<td>Add: Operating table Cardiac monitor Defibrillator Bovie unit</td>
<td>10'-12'</td>
<td>$15,000-$35,000</td>
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<tr>
<td>Level 3: general anesthesia (same as Freestanding Surgical Center)</td>
<td>Hernia repair Hemorrhoids Closed laparoscopy Vaginal tubal Myringotomy with tubes (pediatrics)</td>
<td>Add: Anesthesia machine Autoclave</td>
<td>12'-15'</td>
<td>$35,000-$50,000 or more</td>
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In addition to the availability of the necessary technology, consumer choice is influenced by waiting time, patient procedures (separation from family, type of hospital gown), interpersonal relations, costs, the facility ambiance, and the spatial aspects related to location such as parking and ease of accessibility to the facility. While certain of these factors are outside the control of anesthesia, anesthetists do impact on waiting time, interpersonal relationships and costs.

Although providing quality care is an essential ingredient, it alone will not assure a successful facility. In addition to making the facility easily accessible, the following are essential components that must be incorporated in every facility as part of a strategy to become or remain successful:

1. **The team concept.** Continually interacting within the facility should be three different groups: the surgeons, the patients, and the staff (which includes anesthesia). Professional turf battles must be minimized.

2. **Simplified medical records.** Medical records should be developed that are easy for the surgeon and staff to use and which are specific for the ambulatory surgery patient.

3. **Physician convenience.** Channels of communication should be developed so that information flows freely from the facility to the physician’s office that schedules procedures. Physicians and their office staffs’ level of satisfaction with the facility should be regularly monitored. In 98% of cases is is the physician who determines where the surgery is performed.

4. **V. I. P. (Very Important Patient).** The ambulatory surgery patient is not a second-class citizen. His nevus removal is equally meaningful to him as having a gallbladder removed. Let the patient know how important he or she is by preanesthesia and postanesthesia phone calls and visits, priority registration, patient education brochures, an attractive environment, and limited waiting time.

5. **Careful selection and discharge criteria.** The morning of surgery is not the time to determine that the patient is an unsatisfactory candidate for an ambulatory procedure. Anesthesia must be involved in instructing surgeon’s offices and their staffs what is considered acceptable in the 1980s. Discharge criteria should be practical. A responsible person is necessary to monitor the patient’s care at home. Make the responsible person feel like an important member of the team.

6. **Separate outpatients from inpatients.** The psychology of ambulatory surgery is very important in all aspects. Every effort should be made to have a separate waiting facility and a separate ambulatory surgery postanesthesia care unit.

7. **Be competitive.** In today’s changing health care climate, it is essential that we evaluate the way we deliver health care and make every effort to provide better care, greater convenience to patient and surgeon, and competitive prices. Ambulatory surgery is one of the few areas where we can use the term “cost-effective, quality care” and mean it.

**Conclusion**

The time has come for ambulatory surgery. Merely constructing a facility and opening its doors will not guarantee success. Active participation of all parties involved with the ambulatory surgery facility is required; anesthesia involvement is an essential ingredient of the successful facility.

**REFERENCES**


**AUTHOR**

Bernard V. Wetchler, MD, is a graduate of New York Medical College. He served a rotating internship and a residency in anesthesia at the New York Medical College, Flower and Fifth Avenue Hospital. He is a Fellow in anesthesiology of the American College of Anesthesiologists and a Diplomate of the American Board of Anesthesiologists. Dr. Wetcher is a member of the American Society of Anesthesiologists; President, Society for Ambulatory Anesthesia and a member of the Board of Directors of the Anesthesia Patient Safety Foundation. He has an extensive number of presentations and publications to his credit, including a book entitled Anesthesia for Ambulatory Surgery. Currently, Dr. Wetchler is Director of the Department of Anesthesiology and Medical Director of the Ambulatory Surgery Center at Methodist Medical Center of Illinois in Peoria, Illinois and Clinical Professor and Chief of the Division of Anesthesia of the University of Illinois College of Medicine at Peoria.

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