

Editorial

"In My Experience...Surgeon Control and the Evolution of Outpatient Joint Replacement: A Decade of Progress and the Road Ahead

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The author reviews his multi-year experience with outpatient joint replacement.

INTRODUCTION

The shift from inpatient to outpatient total joint arthroplasty (TJA) is one of the most significant developments in orthopedic surgery in recent years. While systemic health-care pressures and policy changes have influenced this transition, the most consistent and powerful motivator has been the desire among surgeons to reclaim control over the perioperative care process. This article reflects on the evolution of outpatient joint replacement surgery from my perspective, with attention to the clinical, economic, and organizational forces at play.

THE ORIGIN OF OUTPATIENT JOINT REPLACEMENT: SURGEON-LED CHANGE

Early adoption of outpatient joint replacement did not stem from financial incentives or access issues. In my experience, the initial impetus came from frustration with the quality and consistency of inpatient care environments. As surgeons, we understood which protocols—analgesic regimens, DVT prophylaxis, fluid management—we believed would optimize outcomes. Yet, implementation in hospital settings was often hampered by administrative barriers and fragmented care teams.

THE SURGEON'S ROLE IN QUALITY AND VALUE

I believe that surgeons are uniquely positioned to drive quality improvement. Our insight into the timing, appropriateness, and setting of care allows for nuanced decision-making that benefits patients. While some have portrayed outpatient surgery as a universal solution, the goal has never been indiscriminate site shifting. Instead, it has been about thoughtful patient selection and developing reproducible protocols that enhance safety and efficiency.

As surgical programs have matured, it has become evident to me that physician-led care pathways produce superior outcomes. The success of outpatient TJA reflects this broader principle: I truly believe that when physicians direct care, patients benefit. The control of the surgical episode of care can also have significant implications when you start to think about value-based care and healthcare economics. There are studies showing that health systems where physicians hold leadership roles consistently report improved clinical performance and financial stewardship.

However, the shift to outpatient can be challenging for hospitals, whose budgets are built on the margin for high acuity cases such as joint replacement, spine surgery, and cardiac surgery. And, while we don't yet have site neutrality with respect to payor reimbursements, there are many procedures that are reimbursed as outpatient procedures... whether or not the patient stays in the hospital. Therefore, it has been an advantage at our hospital to have built an outpatient program so that we can start to optimize the site of service before the finances are truly impacted. An

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environment built for both quality and value is one with alignment in developing and implementing an outpatient program alongside the critical and necessary inpatient procedures.

COVID-19: CATALYST AND CONFIRMATION

While outpatient programs were steadily gaining traction prior to 2020, the COVID-19 pandemic accelerated their adoption. Hospital shutdowns, patient fears, and system-wide reevaluations of care delivery underscored the safety and convenience of outpatient surgery. Surgeons who had already established ASC pathways were able to rapidly scale, offering safe alternatives during a period of unprecedented disruption.

Today, patients often express a preference for outpatient procedures. That cultural shift has been pivotal, as has the increasing alignment of reimbursement policies with outpatient care. There are of course patients who are not candidates for outpatient surgery and are better served in a hospital setting, or who need to be placed in a rehab center postoperatively because they don't have social support at home or have other non-modifiable considerations.

THE ANATOMY OF A SUCCESSFUL OUTPATIENT PROTOCOL

We have been able to develop our own outpatient protocol and have also worked with many surgeons around the country to help start their surgery centers or to start performing high-acuity surgeries at their surgery centers. Outpatient arthroplasty relies on a well-coordinated, multidisciplinary protocol. In my experience, key elements include:

- **Anesthesia:** Whether general or regional, the anesthetic plan must be consistent and predictable.
- **Fluid Management:** Perioperative fluid management is critical. Preoperative hydration with a sports drink or fluids 2-3 hours prior to surgery is important, as is intraoperative fluid optimization by keeping the patient euvoletic during surgery, and postoperative hydration as well can reduce nausea, dizziness, and urinary retention—improving immediate recovery and patient satisfaction.
- **Blood Management:** Tranexamic acid (TXA) is now standard. The need for transfusion has declined sharply, and preoperative anemia management has become a key safety consideration.
- **Pain Control:** Multimodal pain management—using medications such as nerve blocks, periarticular injections, and/or scheduled oral medications—forms the foundation. There is no universal regimen; centers must develop strategies that are effective and feasible within their resources.

- **Postoperative Care:** A major evolution in our practice has been the first two weeks following knee replacement. Protocols such as the “Quiet Knee” approach, emphasizing rest, elevation, and cryotherapy with delayed formal therapy, have led to significantly improved pain and functional outcomes.

CUSTOMIZATION AND MATURATION OF PROGRAMS

One of the most valuable lessons over the last decade is that there is no singular “correct” protocol. Geographic variability in staffing, medication availability, and institutional culture necessitates flexibility. Surgeons must build protocols that are safe, scalable, and effective “in their hands.”

Collaboration with anesthesia teams, internal medicine partners, and physical therapy providers is essential. Programmatic success hinges on consistency and predictability—not rigid adherence to any one blueprint.

LOOKING AHEAD: 5 TO 15 YEARS

In the next five years, I anticipate the remaining institutional resistance to outpatient TJA will wane. Whether through cultural change or reimbursement reform (e.g., site-neutral payments), economic forces will make inpatient arthroplasty increasingly untenable.

Longer term, the vision becomes more specialized. Specialty hospitals and centers of excellence—particularly for complex revisions and infections—may become regional hubs. While this model raises challenges in patient access and economic impact on local communities, it also offers the potential for superior outcomes through subspecialized care. However, this would require payment reform and solutions for access, certain subsidized care, not to mention workforce and employment considerations.

CONCLUSION

The evolution of outpatient joint replacement is ultimately a story of physician leadership. The desire for control—not in the sense of autonomy for its own sake, but in pursuit of consistent, high-quality patient care—has fueled innovation and improved outcomes. As protocols mature and systems adapt, the focus must remain on what has always mattered most: delivering the best possible care for our patients.

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