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Editorial

Same-Day Discharge in Joint Replacement: From Selective Innovation to Standard Pathway?

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Received: September 27, 2026; **Published:** October 29, 2026

Ten years ago, sending a patient home the same day after a hip or knee replacement would have struck most of us as reckless. I remember colleagues calling it a liability problem waiting to happen. Today it's one of the fastest-growing parts of elective orthopaedic practice, and the literature has largely caught up with the enthusiasm. Roughly two million primary hip and knee replacements are performed each year in the United States alone, and that number is only going up as the population ages. The real question in front of us now isn't whether same-day discharge can be done safely — that argument is mostly settled. It's how far, and how fast, we should be pushing the pathway.

What actually changed

Two things happened at once. Regulators moved first: total knee arthroplasty came off the CMS inpatient-only list in 2018, hip replacement followed in 2020, and reimbursement stopped assuming an overnight stay was mandatory. Clinical practice moved second, and arguably did more of the work — better regional anesthesia, tighter multimodal pain control, less intraoperative blood loss, and mobilization protocols that get patients up and walking within hours rather than days. Together, these shrank the physiologic hit of surgery enough that early discharge stopped being a stunt reserved for the fittest patients and became a realistic plan for a much larger share of them.

The evidence backs this up, mostly. A 2022 systematic review pooling 41 studies on outpatient joint arthroplasty found no meaningful difference in complications or readmissions compared with inpatient care in appropriately selected patients, alongside a real cost advantage. Registry data have echoed that: a Michigan Arthroplasty Registry analysis of over 41,000 primary hip and knee replacements across ambulatory surgery centers, hospital outpatient departments, and traditional hospitals found comparable 90-day outcomes across settings. Worth noting, though — the outpatient cohorts in that dataset were still younger, less comorbid, and less likely to be on Medicaid than the ones kept in hospital. That's not a weakness in the data. It's the data telling us exactly who the pathway currently serves.

The real frontier is who qualifies, not how we operate

What's moving now isn't surgical technique — it's the boundary of who gets offered this option. A study out this year found no correlation between a BMI over 40 and early complications in ambulatory surgery center patients, which would have been an automatic exclusion criterion not long ago. Early series on outpatient revision arthroplasty — long considered untouchable for same-day pathways — suggest carefully chosen revision cases can go home safely too, though I'd treat that evidence as preliminary rather than settled.

That leaves an uncomfortable question for anyone running one of these programs: are we selecting patients well, or just getting away with it at scale so far? The more promising work here uses preoperative patient-reported outcome data to predict who's actually a good candidate for outpatient TKA, rather than leaving it to a surgeon's gut feeling in clinic. Tools like that deserve wider testing across different practice settings before anyone treats them as gospel — but they're a better foundation than "this patient looks healthy to me".

Setting doesn't seem to matter much. Confidence does

One finding that hasn't gotten enough attention: outcomes look similar not just between inpatient and outpatient care, but across outpatient settings themselves. A 2026 comparison of ambulatory surgery centers and hospital outpatient departments found comparable 90-day outcomes between the two, which suggests the safety of this pathway rides on protocol and patient selection far more than on which building the surgery happens in.

What hasn't caught up is trust. Survey work has found that only about half of patients believe an ASC is as safe as a hospital for their surgery, even when the outcomes data say otherwise, and a large share would still rather recover somewhere other than home if given the choice. That gap between what we can show and what patients believe is, to my mind, the most fixable and most ignored part of this whole conversation. We spend a lot of journal space refining anesthetic protocols by a few percentage points. We spend comparatively little on how we counsel patients beforehand, or on making the safety net after discharge visible and credible to them.

It won't look the same everywhere, and that's fine

It's tempting to treat outpatient TJA as a solved problem because a busy community practice or a purpose-built ASC makes it look routine. But a study from a hospital that opened its own affiliated ASC found something worth sitting with: once the healthier patients moved to the ASC, the ones left in the hospital were older and sicker — yet outcomes there held steady or improved, largely because the hospital could concentrate its resources on a smaller, more complex caseload. That's a good outcome, but it's also a reminder that academic centers and safety-net hospitals, which see more medically and socially complex patients to begin with, are not going to replicate ASC-level same-day rates just by copying a protocol. Staffing models, discharge logistics, and postoperative support look different in those settings, and the evidence base for outpatient pathways was largely built in places optimized for it. Extrapolating too freely from ASC data to a county hospital serving a very different population is asking for trouble.

Where that leaves us

Outpatient joint replacement has gone from proof-of-concept to a standard offering, and there's no putting that back in the box. But I don't think the next real gains come from re-proving that the pathway works — that case has been made. They'll come from getting sharper about who it works for, closing the gap between what the data show and what patients believe, and being honest about which practice environments are actually equipped to deliver it safely right now. Patient selection criteria and postoperative safety nets shouldn't be treated as settled protocol. They should be revisited as often as the patients we're sending home the same day keep getting more diverse — in age, in comorbidity, and in how much support they have waiting for them at home [1-8].

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Volume 17 Issue 8 October 2026
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