

American College of Surgeons
Bariatric Surgery Center Network Accreditation Program
(ACS BSCN)



Bariatric
Accreditation
PROGRAM
MANUAL

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CHAPTER 1. Introduction

1A. Introduction: Background

Surgeons from Canada and the United States founded the American College of Surgeons in 1913 for the purpose of improving surgical care with education and setting standards. The organizing surgeons established a Hospital Standards Committee, which became the Joint Commission on Accreditation of Hospitals in 1951. In 1922, the College established the Committee on Trauma (COT) to focus on the care of the injured and by 1976 had codified the principles of trauma care in a publication, *Optimal Hospital Resources for the Care of the Injured Patient*. Due to the increased quantity and complexity of injuries, increased complexities of care, and lessons learned from military surgery, the COT recognized the need for trauma centers and began to encourage development of centers. They also recognized the need for treatment guidelines and clinical pathways and instituted the Advanced Trauma Life Support[®] (ATLS) education programs. The ATLS program continues to save lives worldwide and establishes the effectiveness of guidelines and clinical pathways. Trauma centers following the guidelines created by the COT continued to flourish. By 1987, the Trauma Verification Program was established to document the application of the standards of care. The Trauma Verification Program also includes consultation to assist centers in providing the best resources and practices. Nationwide, 248 trauma centers apply best practices and are verified periodically. Effective trauma care requires more than trauma centers. It requires systems of integrated resources and processes. The COT defined the systems approach in 1993. High-quality care requires evaluation of outcomes. The National Trauma Data Bank[®] now provides a database of 1.5 million patient records to evaluate the safety and effectiveness of trauma care.

The American College of Surgeons organized the Commission on Cancer (COC) in 1922. The COC's 100 members represent 38 national professional organizations and thus, all medical disciplines engaged in providing cancer care. It effectively establishes standards for cancer programs and evaluates programs according to those standards, coordinates the collection, analysis, and dissemination of cancer data, coordinates the activities of a national network of 1,500 physician-volunteers, and provides oversight for cancer education programs. The COC oversees 1,425 cancer centers nationwide with an Approvals Program which reviews every approved center with a site visit and data evaluation every three years. The National Cancer Data Base (NCDB), established in 1986, contains records of 16 million cancer patients representing 80 percent of cancer care provided in the United States. The NCDB represents a vital tool for quality improvement, research, and direction of national policy. As such, the COC has established centers, standards, processes of care, and used outcomes data to improve the quality of cancer care in the U.S.

For many decades, the COT and COC have practiced the principles of surgical care through quality improvement. They established standards of care and encouraged centers to carry out those standards. Quality improvement requires identification and implementation of best practices, documentation of the application of best practices, reliable outcomes data, and the safe, timely introduction of new knowledge and new technology into the standard of care. The COT and COC have been at the forefront of efforts to improve the quality of surgical patient care.

The leaders of the American College of Surgeons recognize the urgent and pressing need to extend these established quality improvement practices beyond trauma and cancer into all disciplines of surgical care. For that reason, on February 12, 2005, the Board of Regents instructed College staff to develop additional center networks, establish standards of care, provide reliable outcome data, develop approvals/verification processes for hospitals and outpatient facilities, and to establish credentialing criteria for surgeons. These additional centers could address diseases, procedures, and disciplines. Because of the timeliness of the matter, the Board of Regents indicated highest priority for developing bariatric surgery center networks.

In the United States, more than 11 million people suffer from severe obesity, and the numbers continue to increase. Obesity increases the risks of morbidity and mortality because of its serious associated comorbidities such as type II diabetes, hypertension, dyslipidemia, cardiovascular disease, stroke, sleep apnea, gallbladder disease, fatty liver, osteoarthritis, and some forms of cancer. In addition, obesity interferes with the activities of daily living and invites social stigmatization. At the present time, surgery provides the only effective, lasting relief from severe obesity.

1B. Introduction: Accreditation Program Manual

This document describes the necessary physical resources, human resources, clinical standards, surgeon credentialing standards, data reporting standards, and verification/approvals processes for the American College of Surgeons Bariatric Surgery Center Network (ACS BSCN) Accreditation Program. The ACS BSCN Advisory Committee may change or modify the processes, standards, and stipulations set forth in this document as new knowledge, new technology, and experience require.

CHAPTER 2. Program Description: American College of Surgeons Bariatric Surgery Centers

2A. Program Description: ACS Accredited Bariatric Surgery Centers – Purpose

Most, if not all, patients with severe obesity fail to achieve and maintain healthy weight with nonsurgical treatments. In 1991, a National Institutes of Health Consensus Conference recognized these assertions, acknowledged the usefulness of surgical treatment in selected patients, and recommended criteria to assist in selecting patients for surgical treatment of morbid obesity. These criteria include a body mass index (BMI) ≥ 40 kg/m² or a BMI ≥ 35 kg/m² associated with major medical complications of obesity such as cardiovascular disease, type II diabetes, and sleep apnea. Some patients who undergo weight-loss surgery have higher risks of complications. Increased risks of mortality include revisional surgery, increased BMI, male gender, and increased age. Patients older than 50 with a BMI ≥ 50 kg/m² have elevated risk. Type II diabetes, hypertension, obstructive sleep apnea, and other comorbidities may also contribute to increased operative risk.

Scrutiny of contemporary weight-loss surgery reveals a need for organization, standards, and data on outcomes. The decision to recommend surgery for obese patients requires multidisciplinary input to evaluate the indications for operation and to define and manage comorbidities properly. Institutions providing weight-loss surgery must have certain commitment, organization, leadership, human resources, and physical resources to provide optimal care. The professionals must demonstrate the necessary training, skills, and experience. Further, high-quality surgical care requires documentation with reliable measurements of outcomes. For these reasons, the ACS BSCN Accreditation Program recognizes and commends those facilities that implement defined standards of care, document their outcomes, and participate in periodic reviews and on-site verification of their bariatric surgery programs. To improve quality and facilitate access to care for patients, the ACS BSCN has developed standards to accredit bariatric surgery centers.

2B. Program Description: ACS Accredited Bariatric Surgery Centers – Accredited Center Levels

This document describes the standards delineating five levels of inpatient facilities, as well as standards for two levels of outpatient surgical care facilities.

The ACS BSCN Program recognizes certain hospitals as Level 1A and 1B Bariatric Surgery Centers. Such hospitals provide complete care devoted to bariatric surgery. These hospitals can manage the most challenging and complex patients with optimal opportunity for safe and effective outcome. They have high-volume practices conducted by professional services of breadth and depth. Level 1A facilities are designated as participants in ACS NSQIP.

Recognizing the need for access to bariatric surgery and that high-quality surgical care occurs in facilities other than high-volume centers, the ACS BSCN Program designates

certain facilities as Level 2A, 2B, and 2-New Bariatric Surgery Centers. These centers provide high-quality care to a lower volume of patients having lesser obesity and lesser comorbidities. Level 2A facilities are designated as participants in ACS NSQIP.

The ACS BSCN Program recognizes Outpatient and Outpatient-New Bariatric Surgery Centers for the application and adjustment of laparoscopic gastric bands. These outpatient surgical centers provide high-quality surgical care devoted to bariatric surgery.

CHAPTER 3. Level 1A and 1B Bariatric Surgery Centers

Level 1A and 1B Bariatric Surgery Centers engage in all levels of obesity, standards of care for weight-loss operations, all ages, comorbid conditions, and reoperations.

3A. Program Standards: Level 1A and 1B Centers

3A.1. Institutional requirements

- a. Full-service Joint Commission-, American Osteopathic Association (AOA)-, or state-approved hospital
- b. Provided bariatric surgery services for more than one year prior to submission of application
 - i. Centers in operation for > two years must provide data for last two years
 - ii. Centers in operation for < two years must provide all data to date
- c. Provided at least 125 primary weight-loss operations during the past 12 months
- d. Key staff
 - i. Two or more bariatric surgeons required
 - ii. Director of bariatric surgery
 - 1) Must meet Level 1 bariatric surgeon requirements (below) and surgeon credentialing criteria (Chapter 10)
 - 2) Reports to department of surgery or hospital administration
 - iii. Bariatric surgery coordinator
 - 1) Nurse or physician assistant
 - 2) Reports to director of bariatric surgery
 - 3) Ensures submission of outcomes data
 - 4) Maintains call schedule with bariatric surgeons

3A.2. Surgeon requirements

- a. Bariatric surgeons
 - i. Certification
 - 1) Certified or recertified by American Board of Surgery (ABS) or American Osteopathic Board of Surgery (AOBS); or,
 - 2) ABS/AOBS board eligible, which is contingent upon completion of oral ABS/AOBS examination; and,
 - 3) Non-board-certified surgeons will be considered on a case-by-case basis on the following factors:
 - (a) Experience: training, leadership, achievements, and outcomes
 - (b) Demonstration of good standing by holding bariatric surgery privileges with the institution seeking accreditation
 - (c) Licensing
 - (d) Fellowship

- ii. At least two bariatric surgeons
 - 1) Each performed at least 100 weight-loss operations over previous 24 months
 - 2) Abide by surgeon credentialing criteria (Chapter 10)
 - 3) Required to be present at facility for significant amount of time
 - 4) Must be on call schedule
 - 5) Provide coverage when other surgeon is unavailable
 - iii. Additional bariatric surgeons encouraged, but not required, to have performed at least 100 operations over previous 24 months
 - iv. Pre- to postoperatively comanaged primary and secondary operations can be included in surgeon volume
 - v. Postoperatively: Refer each patient to physician of patient's choice for long-term medical management
 - vi. Maintain call schedule with bariatric surgery coordinator
- b. All surgeons caring for bariatric surgery patients
 - i. Certified by ABS or AOBS
 - ii. Experienced in care of bariatric surgery patients
 - iii. Capable of managing full range of bariatric surgery-related complications
- c. Qualified surgeons in (b) and bariatric surgeons are responsible for bariatric surgery patients 24 hours per day, seven days per week, and 365 days per year (24/7/365).

3A.3. Services

- a. Multispecialty services
 - i. Offered preoperatively and postoperatively
 - ii. Hospital must have active staff in each of the following:
 - 1) Pulmonology
 - 2) Cardiology
 - 3) Intensive care
 - 4) Infectious disease
 - 5) Nephrology
 - 6) Psychiatry/Psychology
 - 7) Gastroenterology
 - 8) Thoracic Surgery
 - 9) Otolaryngology
 - 10) Orthopedics
- b. Anesthesiology
 - i. Anesthesiologists
 - 1) Board certified
 - 2) Competence in managing patients with obesity
 - 3) Experience managing complex airway issues
 - 4) Demonstrate major time commitment to bariatric surgery patients
 - ii. Provide perioperative and postoperative active pain control including:
 - 1) Drug management
 - 2) Patient-controlled analgesia
 - 3) Epidural techniques

- c. Critical care unit(CCU)/Intensive care unit (ICU)
 - i. Required personnel
 - 1) Physician/surgeon/intensivist staffing 24/7/365
 - 2) Trained critical care nursing staff
 - ii. Equipped for patients with morbid obesity
 - iii. Full-service, full-time emergency room (ER) staffed with ER physicians
- d. Comprehensive endoscopy services
 - i. Trained nursing staff responsible for performing upper gastrointestinal (GI) endoscopy and bronchoscopy
 - ii. Available 24/7/365
- e. Comprehensive minimally invasive surgery
 - i. Complete staff, equipment, and experience in GI tract, biliary system, and abdominal organs including anastomotic procedures
 - ii. Dedicated nursing team with training, experience, and interest in bariatric and minimally invasive surgeries
- f. Comprehensive imaging services
 - i. Radiology unit equipment adequate for bariatric patients:
 - 1) Oversized computed tomography equipment
 - 2) Oversized magnetic resonance equipment
 - ii. Provide complete interventional radiology services

3A.4. Facilities

- a. Full-service operating rooms
 - i. Tables/equipment must accommodate bariatric surgery patients, for example,:
 - 1) Weight capacities of operating tables
 - 2) Retractors
 - 3) Stapling instruments
 - 4) Long surgical instruments
 - 5) Other supplies unique to bariatric surgery
 - ii. Dedicated nursing team with special training/interest in bariatric and minimally invasive surgeries
- b. Recovery room
 - i. Nursing staff experienced in managing patients with morbid obesity
 - ii. Equipment accommodates patients with morbid obesity
 - 1) Special stretchers
 - 2) Lifting devices
 - 3) Other equipment
- c. Emergency room staffed 24/7/365 with ER physicians and support staff
- d. Renal unit provides care for acute renal failure, for example, hemodialysis

- e. Required accommodations for patients with morbid obesity include:
 - i. Shower rooms
 - ii. Room furniture
 - iii. Beds
 - iv. Scales
 - v. Wheelchairs
 - vi. Litters
 - vii. Floor-mounted toilets
 - viii. Doorways
 - ix. Blood pressure cuffs
 - x. Abdominal binders
 - xi. Gowns
 - xii. Walkers
 - xiii. Sequential compression device (SCD) boots
 - xiv. Patient movement/transport systems

3A.5. Personnel

- a. Surgeon credentialing criteria described in Chapter 10
- b. Trained staff includes:
 - i. Nurses
 - ii. Nurse practitioners
 - iii. Physician assistants
 - iv. Physical/exercise therapists
 - v. Nutritionists/dieticians

* Individuals specifically designated to coordinate the care of bariatric surgery patients will provide staff leadership and organization.

3A.6. Processes

- a. Mandatory outcomes reporting
 - i. All centers must report outcomes on all bariatric surgery patients
 - ii. Level 1A Centers are required to participate in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) in addition to reporting outcomes data to the ACS Bariatric Workstation (described in Chapter 11)
 - iii. Level 1B Centers will use the ACS Bariatric Workstation (described in Chapter 11)
 - iv. In addition to criteria listed in Chapter 10, the center must review outcomes data as part of the surgeon credentialing process
- b. Quality improvement (QI) program
 - i. Must have established QI program that includes best practices and monitoring implementation
 - ii. Level 1A enrollment requires documentation of NSQIP membership
 - iii. QI program to be reviewed during site visit

- c. Use of best evidence guidelines, clinical pathways, and algorithms
 - i. Must employ practice guidelines
 - ii. Develop and implement clinical pathways
 - iii. (i) and (ii) to be reviewed during site visit

- d. Education and training of bariatric surgeons
 - i. May provide bariatric surgery training to surgeons
 - ii. May have a bariatric surgery fellowship
 - iii. Allow selected and mutually acceptable surgeons to observe patient care for educational and QI purposes

- e. Patient selection–Multidisciplinary clinical group reviews candidates to evaluate:
 - i. Indications for surgery
 - ii. Contraindications for surgery
 - iii. Comorbidities
 - iv. Operative risks

- f. Patient education, counseling, and informed consent–Establish procedures for:
 - i. Pre- and postoperative patient education
 - ii. Counseling
 - iii. Obtaining informed consent and informed assent (described in Chapter 6)

- g. Discharge and follow-up plan
 - i. At hospital discharge, patient should receive instructions regarding:
 - 1) Activity
 - 2) Diet
 - 3) Wound care
 - 4) Symptoms of complications
 - ii. Follow-up visits should occur frequently. For example:
 - 1) Two weeks postoperatively
 - 2) Several weeks later as indicated
 - 3) Three months
 - 4) Six months
 - 5) One year
 - 6) Every year thereafter

- h. Postoperative rehabilitation and long-term follow-up (as described in Chapter 7)

CHAPTER 4. Level 2A, 2B, and 2-New Bariatric Surgery Centers

Level 2A and 2B Bariatric Surgery Centers will be housed in general acute care hospitals and provide primary weight-loss operations for morbidly obese patients under the age of 60 and in absence of significant cardiac or pulmonary comorbidities. In addition, they are not approved for operations on high-risk patients, such as males with a BMI ≥ 55 , females with a BMI ≥ 60 , or any nonambulatory patients or elective revisional operations for failed weight loss.

4A. Program Standards: Level 2A and 2B Centers

4A.1. Institutional requirements

- a. Full-service Joint Commission-, AOA- , or state-approved hospital
- b. Performed bariatric surgery for more than one year prior to submission of application, unless a new center (see Level 2-New standards below)
 - i. Centers in operation for $>$ two years must provide data for last two years
 - ii. Centers in operation for $<$ two years must provide all data to date
- c. Provided at least 25 primary weight-loss operations during past 12 months
- d. Key staff
 - i. One or more bariatric surgeons
 - ii. Director of bariatric surgery
 - 1) Must meet Level 2 bariatric surgeon requirements (below) and surgeon credentialing criteria (Chapter 10)
 - 2) Reports to department of surgery or hospital administration
 - iii. Bariatric surgery coordinator
 - 1) Nurse or physician assistant
 - 2) Reports to director of bariatric surgery and bariatric surgeons
 - 3) Organizes bariatric program

4A.2. Surgeon requirements

- a. Bariatric surgeons
 - i. Certification
 - 1) Certified or recertified by American Board of Surgery (ABS) or American Osteopathic Board of Surgery (AOBS); or,
 - 2) ABS/AOBS board eligible which is contingent upon completion of oral ABS/AOBS examination; and,
 - 3) Non-board-certified surgeons will be considered on a case-by-case basis on the following factors:
 - (a) Experience: training, leadership, achievements, and outcomes
 - (b) Demonstration of good standing by holding bariatric surgery privileges with the institution seeking accreditation
 - (c) Licensing
 - (d) Fellowship

- ii. At least one bariatric surgeon
 - 1) Each performed at least 50 weight-loss operations over previous 24 months
 - 2) Must have experience performing laparoscopic adjustable gastric banding procedures
 - 3) Must have operating privileges at an inpatient facility
 - 4) Abide by surgeon credentialing criteria (Chapter 10)
 - iii. Additional bariatric surgeons encouraged, but not required, to have performed at least 50 operations over previous 24 months
- b. All surgeons caring for bariatric surgery patients
- i. Certified by ABS or AOBS
 - ii. Experienced in care of bariatric surgery patients
 - iii. Capable of managing full range of complications associated with bariatric surgery
- c. Qualified surgeons in (b) and bariatric surgeons will be responsible for bariatric surgery patients 24/7/365

4A.3. Services

- a. Medical specialty services will be readily available
- b. Anesthesiologists
 - i. Board certified
 - ii. Competence in managing patients with obesity
 - iii. Experience managing complex airway issues
 - iv. CRNA(s) with supervising anesthesiologist
- c. Critical care unit (CCU)/Intensive care unit (ICU)
 - i. Required personnel
 - 1) Physician/surgeon/intensivist staffing 24/7/365
 - 2) Trained critical care nursing staff
 - ii. Equipped for patients with morbid obesity
- d. Other services accommodating to needs of patients with morbid obesity
 - i. Endoscopy services
 - ii. Minimally invasive surgery facilities
 - iii. Imaging services

4A.4. Facilities

- a. Full service operating rooms
 - i. Tables/equipment must accommodate bariatric surgery patients
 - 1) Weight capacities of operating tables
 - 2) Retractors
 - 3) Stapling instruments
 - 4) Long surgical instruments
 - 5) Other supplies unique to bariatric surgery
 - ii. Dedicated nursing team with training in bariatric surgical procedures

- b. Recovery room
 - i. Nursing staff experienced in managing patients with morbid obesity
 - ii. Equipment accommodates patients with morbid obesity
 - 1) Special stretchers
 - 2) Lifting devices
 - 3) Other equipment
- c. Emergency room staffed 24/7/365
- d. Dialysis capability within the building or unit
- e. Required accommodations for patients with morbid obesity include:
 - i. Shower rooms
 - ii. Room furniture
 - iii. Beds
 - iv. Scales
 - v. Wheelchairs
 - vi. Litters
 - vii. Floor-mounted toilets
 - viii. Doorways
 - ix. Blood pressure cuffs
 - x. Abdominal binders
 - xi. Gowns
 - xii. Walkers
 - xiii. Sequential compression device (SCD) boots
 - xiv. Patient movement/transport systems

4A.5. Personnel

- a. Surgeon credentialing criteria described in Chapter 10
- b. Trained staff includes:
 - i. Nurses
 - ii. Nurse practitioners
 - iii. Physician assistants, as needed
 - iv. Physical therapists
 - v. Nutritionists/dieticians

4A.6. Processes

- a. Mandatory outcomes reporting
 - i. All ACS BSCN Centers must report outcomes on all patients who undergo weight-loss surgery
 - ii. Level 2A Centers are required to participate in the ACS NSQIP in addition to reporting outcomes data to the ACS Bariatric Workstation (described in Chapter 11)

- iii. Level 2B Centers will use the ACS Bariatric Workstation (described in Chapter 11)
 - iv. In addition to criteria listed in Chapter 10, the center must review outcomes data as part of the surgeon credentialing process
 - b. Quality improvement (QI) program
 - i. Include promotion and documentation of use of best practices and measuring outcomes
 - ii. Level 2A enrollment requires documentation of NSQIP membership
 - iii. QI program to be reviewed during site visit
 - c. Use of best-evidence guidelines, clinical pathways, and algorithms
 - i. Must employ practice guidelines
 - ii. Develop and implement clinical pathways and algorithms
 - iii. (i) and (ii) to be reviewed during site visit
 - d. Patient selection–Multidisciplinary group of clinicians must review candidates to evaluate:
 - i. Indications for surgery
 - ii. Contraindications for surgery
 - iii. Comorbidities
 - iv. Operative risks
 - e. Patient education, counseling, and informed consent–Establish procedures for:
 - i. Pre- and postoperative patient education
 - ii. Counseling
 - iii. Obtaining informed consent and informed assent (described in Chapter 6)
 - f. Discharge and follow-up plan
 - i. At hospital discharge, patient should receive instructions regarding:
 - 1) Activity
 - 2) Diet
 - 3) Wound care
 - 4) Symptoms of complications
 - ii. Follow-up visits should occur frequently. For example:
 - 1) Two weeks postoperatively
 - 2) Several weeks later as indicated
 - 3) Three months
 - 4) Six months
 - 5) One year
 - 6) Every year thereafter
- a. Postoperative rehabilitation and long-term follow-up (as described in Chapter 7)

4B. Program Standards: Level 2-New Centers

4B.1. Institutional requirements

A new center may apply when:

- a. It has performed at least 25 primary weight-loss operations and
- b. Satisfied Level 2 standards (see 4A) excluding volume and time requirements

4B.2. Accreditation process

- a. Site visit conducted within three months of provisional approval
 - i. To verify infrastructure
 - ii. To evaluate data
- b. Data monitored quarterly and under specific scrutiny

4B.3. Eligibility for Level 1 designation

- a. After one year of accreditation as Level 2-New
- b. Must meet volume requirements of 125 operations annually
- c. Must meet all other Level 1 standards

CHAPTER 5. Outpatient and Outpatient-New Bariatric Surgery Centers

Outpatient Bariatric Surgery Centers are ambulatory surgery facilities recognized for specific types of procedures. Laparoscopic adjustable gastric banding is the only qualifying procedure at this time. Outpatient Centers are required to have a designated inpatient surgery center to which patients can be transferred whenever the need arises 24/7/365.

5A. Program Standards: Outpatient Centers

5A.1. Institutional requirements

- a. Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC)-, AOA-, or state-approved outpatient surgical center
- b. Performed bariatric surgery for more than one year prior to submission of application unless a new center (see Outpatient-New standards below)
 - i. Centers in operation for > two years must provide data for last two years
 - ii. Centers in operation for < two years must provide all data to date
- c. Provided at least 50 laparoscopic adjustable gastric bands during past 12 months
- d. Key staff
 - i. One or more bariatric surgeons
 - ii. Director of bariatric surgery
 - 1) Must meet outpatient bariatric surgeon requirements (below) and surgeon credentialing criteria (Chapter 10)
 - 2) Reports to outpatient center administration
 - 3) Oversees bariatric program
 - iii. Bariatric surgery coordinator
 - 1) Nurse or physician assistant
 - 2) Reports to director of bariatric surgery and bariatric surgeons
 - iv. Identified physician teams to provide long-term medical management to patients

5A.2. Surgeon requirements

- a. Bariatric surgeons
 - i. Certification
 - 1) Certified or recertified by American Board of Surgery (ABS) or American Osteopathic Board of Surgery (AOBS); or,
 - 2) ABS/AOBS board eligible, which is contingent upon completion of oral ABS/AOBS examination; and,

- 3) Non-board-certified surgeons will be considered on a case-by-case basis on the following factors:
 - (a) Experience: training, leadership, achievements, and outcome
 - (b) Demonstration of good standing by holding bariatric surgery privileges with the institution seeking accreditation
 - (c) Licensing
 - (d) Fellowship
 - ii. At least one bariatric surgeon
 - 1) Each performed or supervised at least 100 weight-loss operations over previous 24 months
 - 2) Must have experience performing laparoscopic adjustable gastric banding procedures
 - 3) Must have operating privileges at an inpatient facility
 - 4) Abide by surgeon credentialing criteria (Chapter 10)
 - iii. Additional bariatric surgeons encouraged, but not required, to have performed at least 100 laparoscopic adjustable gastric banding operations over previous 24 months
- b. Staff of qualified surgeons required 24/7/365 at designated inpatient facility to manage laparoscopic band complications

5A.3. Services

- a. Medical specialty services will be readily available
- b. Anesthesiologists
 - i. Board certified
 - ii. Competence in managing patients with obesity
 - iii. Experience managing complex airway issues
 - iv. CRNA(s) with supervising anesthesiologist
- c. Critical care unit (CCU)/Intensive care unit (ICU)
 - i. Required personnel
 - 1) Physician/surgeon/intensivist staffing 24/7/365
 - 2) Trained critical care nursing staff
 - ii. Equipped for patients with morbid obesity
- d. Radiology services
 - i. Certified radiologist experienced in band adjustment
 - ii. Equipment accommodating patients with morbid obesity
 - iii. Fluoroscopy imaging services
- e. Other services accommodating to the needs of patients with morbid obesity

5A.4. Facilities

- a. Operating rooms
 - i. Operating tables/equipment must accommodate bariatric surgery patients
 - 1) Operating tables
 - 2) Retractors
 - 3) Stapling instruments
 - 4) Long surgical instruments
 - 5) Other supplies unique to bariatric surgery
 - ii. Dedicated nursing team with training in bariatric surgical procedures
- b. Recovery room
 - i. Nursing staff experienced in managing patients with morbid obesity
 - ii. Equipment accommodates patients with morbid obesity
 - 1) Special stretchers
 - 2) Lifting devices
 - 3) Other equipment
- c. Ability to transfer patients to a designated inpatient facility with a fully staffed and medically equipped emergency room, ICU/CCU, and an inpatient dialysis unit
- d. Required accommodations for patients with morbid obesity include:
 - i. Office equipment
 - ii. Floor-mounted toilets
 - iii. Doorways
 - iv. Wheelchairs
 - v. Scales
 - vi. Stretchers
 - vii. Examination tables
 - viii. Blood pressure cuffs
 - ix. Gowns

5A.5. Personnel

- a. Surgeon credentialing criteria described in Chapter 10
- b. Trained staff includes:
 - i. Nurses
 - ii. Nurse practitioners
 - iii. Physician assistants, as needed
 - iv. Physical therapists
 - v. Nutritionists/dieticians

5A.6. Processes

- a. Mandatory outcomes reporting
 - i. All ACS BSCN Centers must report outcomes on all patients undergoing weight-loss surgery
 - ii. Outpatient Centers will use the ACS Bariatric Workstation (described in Chapter 11)
 - iii. In addition to criteria listed in Chapter 10, the center must review outcomes data as part of the surgeon credentialing process
- b. Quality improvement (QI) program
 - i. Include promotion and documentation of use of best practices and measuring outcomes
 - ii. QI program to be reviewed during site visit
- c. Use of best-evidence guidelines, clinical pathways, and algorithms
 - i. Must employ practice guidelines
 - ii. Develop and implement clinical pathways and algorithms
 - iii. (i) and (ii) to be reviewed during site visit
- d. Patient selection—Multidisciplinary group of clinicians must review candidates to evaluate:
 - i. Indications for surgery
 - ii. Contraindications for surgery
 - iii. Comorbidities
 - iv. Operative risks
- e. Patient education, counseling, and informed consent—Establish procedures for:
 - i. Pre- and postoperative patient education
 - ii. Counseling
 - iii. Obtaining informed consent and informed assent (described in Chapter 6)
- f. Discharge and follow-up plan
 - i. At hospital discharge, patient should receive instructions regarding:
 - 1) Activity
 - 2) Diet
 - 3) Wound care
 - 4) Symptoms of complications
 - ii. Follow-up visits should occur frequently. For example:
 - 1) Two weeks postoperatively
 - 2) Several weeks later as indicated
 - 3) Three months
 - 4) Six months
 - 5) One year
 - 6) Every year thereafter
- g. Postoperative rehabilitation and long-term follow-up (as described in Chapter 7)

5B. Program Standards: Outpatient-New Centers

5B.1. Institutional requirements

A new center may apply when:

- a. It has performed at least 25 laparoscopic adjustable gastric banding procedures and
- b. Satisfied all Outpatient Center standards (see 5A) excluding volume and time requirements

5B.2. Accreditation process

- a. Site visit conducted within three months of provisional approval
 - i. To verify infrastructure
 - ii. To evaluate data
- b. Data monitored quarterly and under specific scrutiny

CHAPTER 6. Patient Education, Counseling, and Informed Consent

All ACS-accredited Bariatric Centers must establish procedures for patient education, pre- and postoperative counseling, and obtaining informed consent and assent.

6A. Patient education and counseling

6A.1. Patient education

- a. Each surgeon is required to inform patients of his or her experience in performing each type of bariatric surgery
 - i. In verbal or written form
 - ii. As a number or other appropriate measure

6A.2. Patient counseling

- a. Patient should know what to expect during early and long-term postoperative periods through the distribution of printed handouts
- b. Long-term follow-up discussion includes reviewing:
 - i. Quality of life and lifestyle issues
 - ii. Possible late complications

6B. Informed consent

- a. Includes communication with patient regarding description, risks, and benefits of planned procedure
- b. Documents each of the following:
 - i. All educational materials given to patient
 - ii. That patient knows about signs and symptoms of complications common to operation
 - iii. That each patient can recognize signs and symptoms requiring emergency care, for example,:
 - 1) Sustained heart rate ≥ 120 b/min during first 30 days postoperatively
 - 2) Uncontrollable vomiting
 - 3) Abdominal pain.
 - ii. Explains alternative procedures including the option of no operation
 - iii. Includes evidence that patient made educated choice of free will

CHAPTER 7. Postoperative Rehabilitation and Long-term Follow-up

All accredited centers must establish procedures for dietary, exercise, and psychological counseling, plastic surgery consultation, and long-term follow-up.

7A. Postoperative rehabilitation

7A.1. Dietary counseling

- a. Advise patients regarding quantity and quality of food to be ingested postoperatively
- b. Provide advice about vitamins and micronutrients

7A.2. Exercise counseling

- a. Reintroduce physical activity into lifestyle and monitor progress

7A.3. Psychological counseling

- a. Patients may need counseling to address postoperative issues such as:
 - i. Self image
 - ii. Changes occurring in relationships
 - iii. Life changes
- b. Assist with referrals

7A.4. Plastic surgery consultation

- a. Assist with referrals

7B. Postoperative long-term follow-up

- a. Must document at least one year of personal contact with patients; *or*
- b. Must document at least three consecutive contact efforts/attempts, which include:
 - i. Two letters to patient (one must be certified)
 - ii. Phone call to patient
 - iii. Letter to patient's doctor

CHAPTER 8. Accepted Standard Bariatric Surgery Procedures

8A. Accepted standard bariatric surgery procedures: Definition of ACS BSCN standard procedures

For the purposes of the ACS BSCN Program*, the following operations are currently accepted as standard bariatric surgery procedures, when performed by an open or laparoscopic approach:

1. Roux-en-Y Gastric Bypass
2. Laparoscopic Adjustable Gastric Banding
3. Vertical-Banded Gastroplasty
4. Biliopancreatic Diversion with Duodenal Switch
5. Biliopancreatic Diversion without Duodenal Switch
6. Sleeve Gastrectomy
7. Revisional Surgery
8. Urgent or Emergent Surgery Due to Complications from Bariatric Operations (e.g., internal hernia)

8B. Annual Volume Requirements of Centers

8B.1. Level 1 Centers

- a. Must perform at least 125 weight-loss operations annually
- b. Any nonstandard initial operation is considered experimental and may be counted toward the annual volume requirement of 125 weight-loss operations, provided the center receives, and presents to ACS, IRB approval for each type of nonstandard procedure that will be counted toward the annual volume

8B.2. Level 2 Centers

- a. Must perform at least 25 weight-loss operations annually
- b. Any nonstandard initial operation is considered experimental and may be counted toward the annual volume requirement of 25 weight-loss operations, provided the center receives, and presents to ACS, an IRB approval for each type of nonstandard procedure that will be counted toward the annual volume

8B.3. Outpatient Centers

- a. Must perform at least 50 weight-loss operations annually (Outpatient Accredited Bariatric Centers are only approved to perform laparoscopic adjustable gastric banding procedures at this time)

* The ACS Bariatric Advisory Committee will review and update this list as needed.

CHAPTER 9. Bariatric Surgery for Adolescents

Management of child and adolescent morbid obesity requires evaluation by a multidisciplinary weight-management team. While nonoperative weight management is the best option for many adolescents with morbid obesity, physicians have begun considering and offering weight-loss surgery in some cases. The criteria for weight-loss surgery in adolescents require special consideration and standards.

9A. Criteria for adolescent bariatric surgery (*must meet all criteria*)

1. Failed at least six months of organized attempts at weight management, as determined by primary care provider
2. Attained or nearly attained physiological maturity
3. BMI \geq 40 with serious comorbidities or BMI \geq 50
4. Committed to comprehensive medical and psychological evaluations pre- and postoperatively
5. Agreed to avoid pregnancy for a year postoperatively
6. Committed to adhere to nutritional guidelines postoperatively
7. Provided informed assent to surgical treatment
8. Demonstrated decisional capacity
9. Has supportive family environment
10. Agreed to long-term follow-up

9B. Relative contraindications to bariatric surgery in adolescents

1. Medically correctable cause of obesity
2. Substance abuse within the preceding year
3. Psychiatric or cognitive impairment
4. Lactation
5. Pregnancy or planned pregnancy
6. Patient or parent inability to comprehend procedure and its medical consequences

CHAPTER 10. ACS BSCN Surgeon Credentialing Criteria

Surgeon credentialing criteria are procedure specific. In other words, surgeons credentialed in laparoscopic procedures do not qualify for credentialing in open procedures, open does not qualify for laparoscopic, banding does not qualify for gastric bypass, and gastric bypass does not qualify for banding.

10A. Surgeon credentialing criteria: General requirements for newly trained surgeons

10A.1. General surgery residency

- a. Satisfactorily completed a general surgery residency and performed at least 25 laparoscopic bariatric operations and some open bariatric operations or at least 10 open bariatric operations; *or*
- b. Satisfactorily completed a general surgery residency followed by bariatric surgery fellowship and performed at least 25 laparoscopic bariatric operations and some open bariatric operations or at least 10 open bariatric operations; *or*
- c. Satisfactorily performed at least some open bariatric operations during a general surgery residency followed by a minimally invasive surgery fellowship with at least 25 bariatric operations as the operating fellow

10A.2. ABS/AOBS certification: Credentialing requirements

- a. Maintenance of ABS or AOBS certification, or ABS/AOBS board eligible, which is contingent upon completion of ABS/AOBS oral examination
- b. Non-board-certified surgeons will be considered on a case-by-case basis on the following factors:
 - i. Experience: training, leadership, achievements, and outcomes
 - ii. Demonstration of good standing by holding bariatric surgery privileges with the institution seeking accreditation
 - iii. Licensing
 - iv. Fellowship
- c. If surgeon has performed open bariatric operations only, she or he may not be credentialed for laparoscopic bariatric operations
- d. Obtaining Fundamentals of Laparoscopic Surgery (FLS) certification is recommended

10A.3. Surgeon volume requirements

- a. Can include fellowship cases in individual surgeon volume

10A.4. No substantial deviation of bariatric surgery outcomes from accepted norms or benchmarks

10B. Surgeon credentialing criteria: Requirements for established surgeons who wish to perform bariatric surgery

10B.1. Bariatric education and experience

- a. Completion of established didactic course on bariatric surgery
- b. At least 12 weight-loss surgery CME hours must be completed every two years at a bariatric surgery meeting, or other accredited obesity courses, in order to assist in the call schedule
- c. Surgery experience
 - i. Successful completion of 10 open cases (proctored by a credentialed bariatric surgeon); *or*
 - ii. Successful completion of 25 laparoscopic cases (proctored by a surgeon credentialed for laparoscopic weight-loss surgery) and some open cases (proctored by a credentialed bariatric surgeon)
- d. First five independent cases reviewed by designated committee including institution's chief of surgery
- e. If surgeon has performed open bariatric operations only, she or he may not be credentialed for laparoscopic bariatric operations

10B.2. Surgeon credentialing criteria: Recredentialing requirements

- a. Maintenance of ABS or AOBS certification, or ABS/AOBS board eligible, which is contingent upon completion of ABS/AOBS oral examination
- b. Non-board-certified surgeons will be considered on a case-by-case basis on the following factors:
 - i. Experience: training, leadership, achievements, and outcomes
 - ii. Demonstration of good standing by holding bariatric surgery privileges with the institution seeking accreditation
 - iii. Licensing
 - iv. Fellowship
- c. Surgeon credentialing criteria: Lifetime cases
 - i. Each bariatric surgeon who performs 300 lifetime cases will always be considered a bariatric surgeon for purposes of the ACS BSCN program
 - ii. Extent of surgeon's privileges at the institution will be at that institution's discretion

10B.3. Surgeon volume requirements

- a. Performance of 50 primary weight-loss operations during previous 24 months
- b. Documented long-term follow-up of patients

10B.4. No substantial deviation of bariatric surgery outcomes from accepted norms or benchmarks

Chapter 11. Outcomes Data Collection

11A. Outcomes data collection: Level 1A and 2A Centers

11A.1. Must utilize American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) to report outcomes

- a. Must submit data to the Bariatric Workstation developed for ACS BSCN
- b. Trained data collector must report on all weight-loss operations and include long-term follow-up data
- c. Data
 - i. Participants can monitor data 24/7/365 via ACS NSQIP Web site
 - ii. Facility receives semiannual report with confidential ranking in comparison to other participants
 - iii. ACS NSQIP and BSCN Advisory Committees perform confidential review of data. Committee concerns are communicated to facility CEO, director of bariatric surgery, and bariatric surgery coordinator
 - iv. Each facility has annual Inter-rater Reliability visit from a trained, experienced surgical clinical nurse reviewer (SCNR)

11A.2. ACS NSQIP general information

- a. First national validated, risk-adjusted, outcomes-based program to measure and improve quality of care
- b. Utilizes prospective, peer-controlled, validated database
- c. Key components
 - i. Data collection
 - ii. Data monitoring and validation
 - iii. Report generation
 - iv. Data analysis
 - v. Focus on systems, not individual providers
 - vi. Feedback to participants
- d. Key staff
 - i. Surgeon leader required
 - ii. Trained SCNR
 - 1) Collects and submits required data
 - 2) Continued training required
 - 3) Receives annual quality evaluations
- e. For more information on the ACS NSQIP, please visit www.acsnsqip.org

11B. Outcomes Data Collection: Level 1B, 2B, 2-New, Outpatient, and Outpatient-New Centers

11B.1. Report outcomes data to the Bariatric Workstation developed for ACS BSCN

- a. Designated, trained data collector on bariatric surgery center staff must enter data using established protocol

11B.2. Data

- a. Subject to quality control
- b. Entered into database as encrypted and deidentified information to ensure confidentiality
- c. Audited during site reviews (includes chart reviews)
- d. Deidentified data reviewed by ACS BSCN Advisory Committee annually. Committee concerns communicated to facility CEO, director of bariatric surgery, and bariatric surgery coordinator
- e. Only used to report facility's outcomes to ACS for purposes of BSCN Program
- f. Does not have same rigor as ACS NSQIP
 - i. Not risk-adjusted
 - ii. Not used to make comparisons
 - iii. Not used for research
- g. Data reports provided to facility
 - i. Issued annually
 - ii. Sent to facility CEO, director of bariatric surgery, and bariatric surgery coordinator
 - iii. Facility will be able to identify patients and surgeons on reports

CHAPTER 12. ACS BSCN Accreditation Application: Processes

12A. ACS BSCN Accreditation application: Processes—application and site review

12A.1. Facility submits application

- a. Required documents for application submission
 - i. Application
 - ii. CEO letter of support
 - iii. Signed confirmation sheet attesting to validity of information provided

- b. Information requested in application
 - i. Hospital data, for example, case volumes
 - ii. Description of resources
 - iii. Outcomes
 - iv. Joint Commission, AAAHC, and AOA status
 - v. Description of facility, for example,:
 - 1) Operating rooms
 - 2) Recovery rooms
 - 3) Intensive/Critical care units
 - vi. Description of services, for example,:
 - 1) Medical specialties
 - 2) Nursing
 - 3) Dietetic and nutrition
 - 4) Social work
 - 5) Psychology

12A.2. Application is approved or denied by ACS BSCN Advisory Committee

- a. If approved, facility continues accreditation process. Proceed to next section.

- b. If denied, notification letter is sent to facility.

12A.3. ACS and facility complete participation and business associate agreements

- a. Participation agreement delineates each party's responsibilities:
 - i. College's obligations to participating facility
 - ii. Facility's obligations to maintain standards and stipulations of BSCN

- b. Business associate agreement allows the facility to participate in submitting outcomes data to the Bariatric Workstation.
 - i. In addition, Level 1A and 2A Centers must apply to ACS NSQIP separately.

12A.4. Facility submits program fee and signed participation and business associate agreements

- a. Program fee information
 - i. Levels 1A, 1B, 2A, 2B, and Outpatient
 - 1) Payment for three years of accreditation
 - 2) Must resubmit payment when facility seeks reaccreditation
 - ii. Levels 2-New and Outpatient-New
 - 1) Payment for three years of accreditation
 - 2) Must resubmit payment when facility is eligible and applies for Level 1A, 1B, 2A, 2B, or Outpatient designation
- b. Agreements must be signed by representatives from both parties

12A.5. Facility obtains provisional approval status and receives packet

- a. Provisional approval packet includes:
 - i. Notification letter
 - ii. Original, fully executed participation and business associate agreements
 - iii. Pre-Site Review Questionnaire (PSRQ)
 - iv. Site review agenda
 - v. Schedule form

12A.6. Schedule site review date

- a. Site review must be completed
 - i. For Level 1A, 1B, 2A, 2B, and Outpatient: within first six months of receiving provisional approval status
 - ii. For Level 2-New and Outpatient-New: within first three months of receiving provisional approval status
- b. Submit schedule form to ACS BSCN Program Coordinator (please see Appendix B for ACS BSCN Program staff listing)
- c. BSCN Coordinator selects appropriate surgeon site reviewer
 - i. Reviewer must reside/practice in different state or province than facility
 - ii. Reviewer cannot conduct site review if a conflict of interest exists with a particular facility
- d. BSCN Coordinator contacts facility with final date for site review
- e. Facility and BSCN Coordinator finalize site review date

12A.7. Facility submits PSRQ to BSCN Coordinator

- a. Submission must be in Microsoft® Office Word format via e-mail
- b. Must be submitted at least 45 days prior to site review date

12A.8. Site review

- a. Duration is approximately six hours
- b. Starts with pre-review meeting
 - i. Attendees:
 - 1) Site reviewer
 - 2) Director of bariatric surgery
 - 3) Bariatric surgery coordinator
 - 4) Facility CEO
 - 5) Bariatric surgery personnel
 - 6) Other individuals, as necessary
 - ii. Discussion topics:
 - 1) Overall bariatric surgery program
 - 2) Clarification of PSRQ
 - 3) Specific concerns
 - 4) Unique features of the facility
 - 5) Local care of patients with morbid obesity
- c. All bariatric surgery care areas visited
- d. Interviews conducted with:
 - i. Facility administration
 - ii. Director of bariatric surgery
 - iii. Bariatric surgery coordinator
 - iv. Bariatric surgeons
 - v. Anesthesiologists
 - vi. Nursing staff of all units caring for bariatric surgery patients
 - vii. Other appropriate staff
- e. Facility processes reviewed:
 - i. Quality improvement program
 - ii. Best-evidence guidelines
 - iii. Bariatric surgeon education and training
 - iv. Patient selection process
 - v. Patient education
 - vi. Patient discharge
 - vii. Short- and long-term follow-up
 - viii. Various counseling services available
- f. Chart review
 - i. Facility pulls a random sampling of 20 charts or 10 percent of annual case volume (the greater of the two) from the previous 12 months
 - 1) Equal sample from each bariatric surgeon
 - 2) Equal sample of the different weight-loss operations performed
 - ii. Facility pulls all charts from the previous 12 months for patients who:
 - 1) Experienced major complications
 - 2) Experienced minor complications
 - 3) Have died

- g. Exit interview conducted with:
 - i. Facility administration
 - ii. Chief of surgery
 - iii. Director of bariatric surgery
 - iv. Bariatric surgery coordinator
 - v. Others, as deemed by facility administration

- h. Site reviewer completes and submits site review report to ACS BSCN staff

12A.9. Post-site visit

- a. BSCN Advisory Committee
 - i. Reviews all submitted documentation and forms
 - ii. Makes decision regarding full accreditation of facility

- b. BSCN Program Coordinator notifies facility of Advisory Committee's decision

12B. ACS BSCN Accreditation: Appeal process

- a. If ACS denies accreditation, the hospital may appeal, under ACS procedures, to the College's Division of Research and Optimal Patient Care, whose decision shall be final.

Chapter 13. Consultation Services

For inpatient and outpatient facilities interested in developing a bariatric surgery program, the ACS BSCN offers consultation services to assist program development. Only facilities without existing bariatric surgery programs are eligible for this service.

13A. Consultation Services

13A.1. The ACS BSCN will assist in identifying opportunities for

- a. Surgeon training
- b. Proctoring
- c. Preceptoring

13A.2. The ACS BSCN can assist in building a bariatric surgery team

13A.3. The ACS BSCN can assist in organizing consultation with:

- a. Nursing
- b. Anesthesiology
- c. Bariatricians
- d. Other essential team members including:
 - i. Dieticians
 - ii. Social workers
 - iii. Clinical psychologists

APPENDIX A. Consolidated Criteria

To guide a facility in obtaining and maintaining accreditation status, each column summarizes the minimum criteria requirements for each center level.

	Standard	Level 1	Level 2	Level 2-New	Level Outpt.	Level Outpt.-New
1	The Joint Commission-, AOA-, AAAHC- or state-approved hospital	Yes	Yes	Yes	Yes	Yes
2	Case Selection: <ul style="list-style-type: none"> Level 1: Accepts all cases Level 2 and Level Outpatient: Selects and accepts cases based on each Level's criteria restrictions 	Yes – Accepts all cases	Yes – Selects cases per Level criteria	Yes – Selects cases per Level criteria	Yes – Banding cases only per Level criteria	Yes – Banding cases only per Level criteria
3	Facility has performed weight-loss operations for more than one year prior to the submission of application (unless applying for New-center status)	Yes	Yes	No	Yes	No
4	Facility performed $\geq x$ weight-loss operations during the past 12 months	125	25	25*	50	25*
5	Has a director of bariatric surgery	Yes	Yes	Yes	Yes	Yes
6	Has a bariatric surgery coordinator	Yes	Yes	Yes	Yes	Yes
7	Director and active bariatric surgeons are ABS or AOBS certified (if no, surgeons will be considered on a case-by-case basis per the Accreditation Program Manual, Chapter 10)	Yes	Yes	Yes	Yes	Yes
8	A minimum number of active surgeons who each must have conducted $\geq x$ weight-loss operations over previous 24 months	At least two surgeons conducted ≥ 100 operations each	At least one surgeon conducted ≥ 50 operations each	At least one surgeon conducted ≥ 50 operations each	At least one surgeon conducted or supervised ≥ 100 bands each	At least one surgeon conducted or supervised ≥ 100 bands each
9	Facility has active staff in the following specialties: <ul style="list-style-type: none"> Cardiology Gastroenterology Intensive Care Infectious Disease Nephrology Orthopedics Otolaryngology Psychiatry/Psychology Pulmonology Thoracic Surgery <i>(Level 1 centers must have active staff in all of the above.)</i>	Yes to All	Selected	Selected	Selected	Selected
10	Anesthesiologist <ul style="list-style-type: none"> Level 1: A full-time board-certified anesthesiologist provides full coverage for all weight-loss procedures Levels 2, 2-New, Outpatient, and Outpatient-New: A full-time board-certified anesthesiologist provides full coverage for all weight-loss procedures or CRNAs with a supervising anesthesiologist are acceptable. 	Yes	Yes	Yes	Yes	Yes
11	Full coverage of pain service	Yes	Optional	Optional	Optional	Optional
12	Fully staffed and medically equipped for morbidly obese patients:					
	<ul style="list-style-type: none"> Operating room 	Yes	Yes	Yes	Yes	Yes
	<ul style="list-style-type: none"> Recovery room 	Yes	Yes	Yes	Yes	Yes
	<ul style="list-style-type: none"> Emergency room 	Physician/24 hours	Staff/24 hours	Staff/24 hours	No**	No**
	<ul style="list-style-type: none"> Intensive/Critical care unit 	Physician/24 hours	Physician/PM schedule	Physician/PM schedule	No**	No**
13	Performs endoscopy procedures for morbidly obese	Yes	Yes	Yes	Optional	Optional
14	Performs minimally invasive procedures for morbidly obese	Yes	Yes	Yes	Yes	Yes
15	Imaging service is equipped for morbidly obese	Yes	Yes	Yes	Fluoroscopy	Fluoroscopy
16	General accommodations for morbidly obese	Yes	Yes	Yes	Yes	Yes
17	Employs practice guidelines and implements clinical pathways	Yes	Yes	Yes	Yes	Yes

Standard		Level 1	Level 2	Level 2-New	Level Outpt.	Level Outpt.-New
18	Agrees to report outcomes data	<i>1A Centers:</i> ACS NSQIP & ACS BSCN	<i>2A Centers:</i> ACS NSQIP & ACS BSCN	ACS BSCN	ACS BSCN	ACS BSCN
		<i>1B Centers:</i> ACS BSCN	<i>2B Centers:</i> ACS BSCN			
19	Has an established quality improvement program	Yes	Yes	Yes	Yes	Yes
20	Reviews outcomes data as part of the facility's surgeon credentialing process	Yes	Yes	Yes	Yes	Yes
21	Multidisciplinary group reviews candidates in the patient selection process	Yes	Yes	Yes	Yes	Yes
22	Patient education on pre- and postoperative expectations through the distribution of printed handouts	Yes	Yes	Yes	Yes	Yes
23	Extensive explanation of informed consent and assent	Yes	Yes	Yes	Yes	Yes
24	Each surgeon informs the patient of his or her experience in performing various types of bariatric surgery, in verbal or written form, as a number or other measure	Yes	Yes	Yes	Yes	Yes
25	Protocol in place for patient discharge including instructions for activity, diet, wound care, and symptoms of complications	Yes	Yes	Yes	Yes	Yes
26	Protocol in place for patient follow-up (e.g., at two weeks postop, several weeks later as indicated, three months, six months, one year, and every year thereafter)	Yes	Yes	Yes	Yes	Yes
27	Protocol of patient rehabilitation including dietary, exercise, psychological, plastic surgery counseling, and long-term follow-up	Yes	Yes	Yes	Yes	Yes

* Centers can apply as Level 2-New and Outpatient-New once they have conducted 25 weight-loss operations, or 25 laparoscopic gastric banding procedures, respectively. Time requirements do not apply.

** A designated inpatient facility with a fully staffed and medically equipped Emergency Room, Intensive/Critical Care Unit, and Dialysis Unit are available 24/7/365 for patient transfer.

Abbreviations: AOA, American Osteopathic Association; AAAHC, Accreditation Association for Ambulatory Health Care; ABS, American Board of Surgery; AOBS, American Osteopathic Board of Surgery; ACS NSQIP, American College of Surgeons National Surgical Quality Improvement Program; ACS BSCN, American College of Surgeons Bariatric Surgery Center Network Program; ACS, American College of Surgeons

Appendix B. ACS BSCN Program Staff

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