ACS BSCN 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, 334 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 over four 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 more than 100 members represent 48 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 close to 1,500 cancer programs nationwide with an Accreditation Program which reviews every accredited program with a site visit and data evaluation every three years. The National Cancer Data Base (NCDB), established in 1986, contains records of 20 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 70 million people suffer from 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/m^2 or a BMI ≥ 35 kg/m^2 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/m^2 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 three 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 1 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.

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 2 and 2-New Bariatric Surgery Centers. These centers provide high-quality care to a lower volume of patients having lesser obesity and lesser comorbidities.

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 1 Bariatric Surgery Centers

Level 1 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 1 Centers

3A.1. Institutional requirements

a. Full-service Joint Commission-, American Osteopathic Association (AOA)-, Det Norske Veritas (DNV)-, 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. One 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) Licensed healthcare professional
      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), American Osteopathic Board of Surgery (AOBS), or Royal College of Physicians and Surgeons of Canada (RCPSC); or,
      2) ABS/AOBS/RCPSC board eligible, which is contingent upon completion of oral ABS/AOBS/RCPSC 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
(e) Documentation of the following:
  (i.) Completion of an approved General Surgery Residency with a letter of recommendation from the program director verifying that the surgeon received sufficient training in bariatric surgery to practice the procedure safely, and provide a case log of the cases the resident performed or assisted on in residency
  (ii.) Credentialed with full unrestricted privileges in bariatric surgery at the facility
  (iii.) Completion of an approved fellowship post residency in bariatric surgery or a fellowship which included exposure to the performance and management of bariatric surgery (i.e. laparoscopic fellowship) with a letter of recommendation from the program director that the surgeon is qualified in bariatric surgery, and provides a case log of cases
  (iv.) Membership and participation in nationally recognized professional societies such as American College of Surgeons (ACS), American Society for Metabolic and Bariatric Surgery (ASMBS), Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), or The Society for the Surgery of the Alimentary Tract (SSAT)
  (v.) Continuing Medical Education (CME) for the previous 2 years consistent with the requirements of the ABS Maintenance of Certification (MOC) program (100 hours with 60 hours Category 1 and 40 hours of Category 2), 30 hours of the CME must be in bariatric surgery
  (vi.) Publication of peer review articles on bariatric surgery
  (vii.) Provide a case log with outcomes over the previous 3 years, with the completion of at least 100 bariatric cases as the primary surgeon over the prior 24 months

ii. At least one bariatric surgeon
  1) Performed at least 100 weight-loss operations over previous 24 months (facility requirements of at least 125 annual cases must still be met)
  2) Abide by surgeon credentialing criteria (Chapter 10)
  3) Required to be present at facility for significant amount of time
  4) Must be on the bariatric surgery specific call schedule

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. Fellowship cases can be included in surgeon volume

vi. Postoperatively: Refer each patient to physician of patient's choice for long-term medical management

vii. Maintain call schedule with bariatric surgery coordinator

b. Qualified coverage for bariatric surgeons
  i. Bariatric surgery specific call schedule is required 24 hours a day, 7 days a week

ii. Surgeons on the call schedule must be:
   1) Trained and qualified general surgeons with experience in dealing with upper gastrointestinal problems
   2) Complete a didactic course which specializes in bariatric surgery complications
   3) Highly recommend that the general surgeon has experience in working with the bariatric surgeon

3A.3. Services

a. Multispecialty services
   i. Offered preoperatively and postoperatively
   ii. Hospital must have active staff readily available throughout the year 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) Imaging and Interventional Radiology
      10) Vascular Surgery
      11) Anesthesiology
      12) Endoscopy
      13) Minimally Invasive Surgery

b. Anesthesiology
   i. Anesthesiologists
      1) Board certified or board eligible, contingent upon completion of the oral exam
      2) The decision of eligibility is based on the decision of the Chief of Anesthesiology
      3) Competence in managing patients with obesity
      4) Experience managing complex airway issues
      5) 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 readily available throughout the year
      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. Must be readily available throughout the year

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
   iii. Must be readily available throughout the year

f. Comprehensive imaging services and interventional capability
   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 with ER physicians and support staff readily available throughout the year

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 or structurally supported 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. NSQIP Participating 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. Non-NSQIP Participating 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. 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 2 and 2-New Bariatric Surgery Centers

Level 2 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 bariatric operations on high-risk patients, such as:

- Males with a BMI ≥ 55 and females with a BMI ≥ 60
- Adolescents (under the age of 18)
- Patients who have:
  a. Organ failure
  b. An organ transplant or
  c. A candidate for transplant
- Any nonambulatory patients or
- Elective revisional intra-abdominal operations (port and tubing revisions are accepted but are not included in the case volume.)

4A. Program Standards: Level 2 Centers

4A.1. Institutional requirements

a. Full-service Joint Commission-, AOA- , DNV-, or state-approved hospital

b. Performed bariatric surgery for more than one year prior to submission of application, unless a new center (see 4.B for Level 2-New standards)
   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) Licensed healthcare professional
      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), American Osteopathic Board of Surgery (AOBS), or Royal College of Physicians and Surgeons of Canada (RCPSC); or,
2) ABS/AOBS/RCPSC board eligible which is contingent upon completion of oral ABS/AOBS/RCPSC 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
    (e) Documentation of the following:
        (i.) Completion of an approved General Surgery Residency with a letter of recommendation from the program director verifying that the surgeon received sufficient training in bariatric surgery to practice the procedure safely, and provide a case log of the cases the resident performed or assisted on in residency
        (ii.) Credentialed with full unrestricted privileges in bariatric surgery at the facility
        (iii.) Completion of an approved fellowship post residency in bariatric surgery or a fellowship which included exposure to the performance and management of bariatric surgery (i.e. laparoscopic fellowship) with a letter of recommendation from the program director that the surgeon is qualified in bariatric surgery, and provides a case log of cases
        (iv.) Membership and participation in nationally recognized professional societies such as American College of Surgeons (ACS), American Society for Metabolic and Bariatric Surgery (ASMBS), Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), or The Society for the Surgery of the Alimentary Tract (SSAT)
        (v.) Continuing Medical Education (CME) for the previous 2 years consistent with the requirements of the ABS Maintenance of Certification (MOC) program (100 hours with 60 hours Category 1 and 40 hours of Category 2), 30 hours of the CME must be in bariatric surgery
        (vi.) Publication of peer review articles on bariatric surgery
        (vii.) Provide a case log with outcomes over the previous 3 years, with the completion of at least 100 bariatric cases as the primary surgeon over the prior 24 months

ii. At least one bariatric surgeon

        1) Each performed at least 50 weight-loss operations over previous 24 months
        2) 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
    iv. Fellowship cases can be included in surgeon volume

b. Qualified coverage for bariatric surgeons
    i. Bariatric surgery specific call schedule is required 24 hours a day, 7 days a week
    ii. Surgeons on the call schedule must be:
        1) Trained and qualified general surgeons with experience in dealing with upper gastrointestinal problems
        2) Complete a didactic course which specializes in bariatric surgery complications
        3) Highly recommend that the general surgeon has experience in working with the bariatric surgeon

4A.3. Services

a. The following specialty services must be readily available throughout the year

b. Anesthesiologists
    i. Board certified or board eligible, contingent upon completion of the oral exam
    ii. The decision of eligibility is based on the decision of the Chief of Anesthesiology
    iii. Competence in managing patients with obesity
    iv. Experience managing complex airway issues
    v. CRNA(s) with supervising anesthesiologist

c. Critical care unit (CCU)/Intensive care unit (ICU)
    i. Required personnel
        1) Physician/surgeon/intensivist staffing readily available throughout the year
        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 with staff readily available throughout the year

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 or structurally supported 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. NSQIP Participating 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. Non-NSQIP Participating 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. 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)

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 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 must have the ability to deal with repair for port and tubing complications due to laparoscopic adjustable gastric banding procedures performed.

5A. Program Standards: Outpatient Centers

5A.1. Institutional requirements

a. Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC)-, AOA-, DNV-, 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) Licensed healthcare professional
     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), American Osteopathic Board of Surgery (AOBS), or Royal College of Physicians and Surgeons of Canada (RCPSC); or,
     2) ABS/AOBS/RCPSC board eligible, which is contingent upon completion of oral ABS/AOBS/RCPSC 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
(e) Documentation of the following:
  (i.) Completion of an approved General Surgery Residency with a letter of recommendation from the program director verifying that the surgeon received sufficient training in bariatric surgery to practice the procedure safely, and provide a case log of the cases the resident performed or assisted on in residency
  (ii.) Credentialed with full unrestricted privileges in bariatric surgery at the facility
  (iii.) Completion of an approved fellowship post residency in bariatric surgery or a fellowship which included exposure to the performance and management of bariatric surgery (i.e. laparoscopic fellowship) with a letter of recommendation from the program director that the surgeon is qualified in bariatric surgery, and provides a case log of cases
  (iv.) Membership and participation in nationally recognized professional societies such as American College of Surgeons (ACS), American Society for Metabolic and Bariatric Surgery (ASMBS), Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), or The Society for the Surgery of the Alimentary Tract (SSAT)
  (v.) Continuing Medical Education (CME) for the previous 2 years consistent with the requirements of the ABS Maintenance of Certification (MOC) program (100 hours with 60 hours Category 1 and 40 hours of Category 2), 30 hours of the CME must be in bariatric surgery
  (vi.) Publication of peer review articles on bariatric surgery
  (vii.) Provide a case log with outcomes over the previous 3 years, with the completion of at least 100 bariatric cases as the primary surgeon over the prior 24 months

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

iv. Fellowship cases can be included in surgeon volume

b. Staff of qualified surgeons are required to be readily available throughout the year at designated inpatient facility within a 30-minute proximity to manage laparoscopic band complications

5A.3. Services

a. The following specialty services must be readily available throughout the year

b. Anesthesiologists
   i. Board certified or board eligible, contingent upon completion of the oral exam
   ii. The decision of eligibility is based on the decision of the Chief of Anesthesiology
   iii. Competence in managing patients with obesity
   iv. Experience managing complex airway issues
   v. CRNA(s) with supervising anesthesiologist

c. Designated inpatient facility
   i. Required to have a service agreement with a designated inpatient surgery center for the following:
      1) Ability to transfer patients within a 30-minute proximity with a fully staffed and medically equipped Emergency Room (ER), Intensive Care Unit (ICU)/Critical Care Unit (CCU), and inpatient dialysis unit
      2) ICU/CCU in which the service agreement must verify the availability of all the inpatient services required
         (a) ICU/CCU
            (i) Required personnel
            (ii) Physician/surgeon/intensivist staffing readily available throughout the year
         (b) Trained critical care nursing staff
         (c) 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. Must have a service agreement to transfer patients to a designated inpatient facility within a 30-minute proximity 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 or structurally supported 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 preformed 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
   iv. Explains alternative procedures including the option of no operation
   v. 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. Letter to patient
   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.
**Port and tubing revisions are not included in the case volume.

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. Level 2 Centers are not approved to perform adolescent bariatric surgery at this time.

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 ≥ 35 with serious comorbidities or BMI ≥ 40
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

ACS BSCN

CHAPTER 10. ACS BSCN Surgeon Credentialing Recommendations

The purpose of credentialing in bariatric operations is to ensure that the surgeon has undergone appropriate training, has the requisite skill and experience to perform the procedure and has the ability to recognize and treat potential complication. While it is recognized that each surgeon assimilates new techniques and technologies at different paces and that number of procedures performed is only a crude measure of expertise, these guidelines offer recommendations to the local credentialing committee regarding adequate training and experience. The final decision regarding an individual surgeon's qualifications remains the responsibility of the institution's credentialing committee, whose ultimate goal should be the safety of the bariatric patient. Each institution must have a uniform standard by which each surgeon is judged. This standard should be adequate to ensure appropriate training, but not so unreasonable so as to be unobtainable, thus limiting access to care for the morbidly obese individual. It is impossible to address the circumstances surrounding each individual surgeon's training and experience. Thus, while these guidelines do not establish the standard of care for granting privileges, they do offer recommendations by which the institution's credentialing committee can evaluate the training and experience of surgeons seeking bariatric surgical privileges.

10A. Credentialing Recommendations

1. Satisfactory completion of an accredited general surgery residency program.
2. Certification by the American Board of Surgery or its equivalent.
3. Has privileges to perform advanced laparoscopic surgery and gastrointestinal surgery.
4. At minimum, formal didactic training in bariatric surgery, including preoperative evaluation and patient selection, operative techniques, and postoperative follow-up.
5. Participation in a structured bariatric program with long-term follow-up.
6. Perform 50 bariatric operations with satisfactory outcomes, of which at least 25 should be stapling or anastomotic procedures.
7. Periodic evaluation of outcomes to ensure that established benchmarks are met.

10B. Recredentialing Recommendations

1. Maintenance of certification by the American Board of Surgery or its equivalent.
2. Performance of 50 primary bariatric operations in the preceding 24 months.
3. Participation in a structured bariatric program with long-term follow-up.
4. Periodic evaluation of outcomes to ensure that established benchmarks are met.
5. At least 12 CME hours in bariatric surgery every two years.
6. A surgeon who has performed 300 lifetime bariatric cases will always be considered a bariatric surgeon for purposes of the ACS BSCN program.

10C. Call Coverage Recommendations

1. 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.

Chapter 11. Outcomes Data Collection

11A. Outcomes Data Collection: NSQIP Participating 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 Website
   ii. 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

11A.2. ACS NSQIP general information

a. First national validated, risk-adjusted, multidisciplinary, 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. Trained data collector
      1) Collects and submits required data
      2) Continued training required

e. For more information on the ACS NSQIP, please visit *www.acsnsqip.org*

11B. Outcomes Data Collection: Non-NSQIP Participating 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

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
      1) Must include outcomes data for all surgeons who have performed bariatric operations at the center during the given time frame, including general surgeons and non-faculty surgeons who are in private and/or community practices.
   ii. Description of resources
   iii. Outcomes
   iv. Joint Commission, AAAHC, AOA, DNV, and state approval 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

c. Two or more facilities under one health system seeking accreditation may apply under a single application if the facilities meet the following standards:
   i. Bariatric Program staff at the centers is substantially the same (i.e. same personnel including leadership).
   ii. The data submission and the data collector(s) are the same.
   iii. The centers are in close proximity of each other.
   iv. The centers meet the required level standards and conduct a site visit for each facility.
   v. Hospitals have identical FEIN numbers and/or are recognized by The Joint Commission as one entity for purposes of accreditation.

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, NSQIP Participating 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 1, 2, 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 1, 2, 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 1, 2, 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.

ACS BSCN

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-, DNV-, or state-approved hospital	Yes	Yes	Yes	Yes	Yes
2	Case Selection: • 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 ≥ *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, AOBS, or RCPSC board-certified or board-eligible (non-board-certified 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 ≥ *x* weight-loss operations over previous 24 months	At least one surgeon con-ducted ≥ 100 operations	At least one surgeon conducted ≥ 50 operations	At least one surgeon conducted ≥ 50 operations	At least one surgeon conducted or supervised ≥100 bands	At least one surgeon conducted or supervised ≥100 bands
9	Qualified coverage for bariatric surgeons: • Bariatric specific call schedule 24/7 • Surgeons on the call schedule: o General surgeons with experience in dealing with upper gastrointestinal problems o Complete didactic course in bariatric complications o Highly recommend general surgeon has experience working with bariatric surgeon	Yes	Yes	Yes	No	No
10	Facility has active staff in the following specialties: • Cardiology • Gastroenterology • Intensive Care • Infectious Disease • Nephrology • Imaging and Interventional Radiology • Vascular Surgery • Psychiatry/Psychology • Pulmonology • Thoracic Surgery • Anesthesiology • Endoscopy • Minimally Invasive Surgery (*Level 1 centers must have active staff in all of the above.*)	Yes to All	Selected	Selected	Selected	Selected
11	Anesthesiologist • Level 1: A full-time board-certified or board-eligible anesthesiologist provides full coverage for all weight-loss procedures • Levels 2, 2-New, Outpatient, and Outpatient-New: A full-time board-certified or board-eligible anesthesiologist provides full coverage for all weight-loss procedures or CRNAs with a supervising anesthesiologist are acceptable.	Yes	Yes	Yes	Yes	Yes
12	Full coverage of pain service	Yes	Optional	Optional	Optional	Optional
13	Fully staffed and medically equipped for morbidly obese patients:					

	Standard	Level 1	Level 2	Level 2-New	Level Outpt.	Level Outpt.-New
	• Operating room	Yes	Yes	Yes	Yes	Yes
	• Recovery room	Yes	Yes	Yes	Yes	Yes
	• Emergency room	Physician/ readily available throughout the year	Staff/ readily available throughout the year	Staff/ readily available throughout the year	No**	No**
	• Intensive/Critical care unit	Physician/ readily available throughout the year	Physician/ readily available throughout the year	Physician/ readily available throughout the year	No**	No**
14	Performs endoscopy procedures for morbidly obese	Yes	Yes	Yes	Optional	Optional
15	Performs minimally invasive procedures for morbidly obese	Yes	Yes	Yes	Yes	Yes
16	Imaging service is equipped for morbidly obese	Yes	Yes	Yes	Fluoroscopy	Fluoroscopy
17	General accommodations for morbidly obese	Yes	Yes	Yes	Yes	Yes
18	Employs practice guidelines and implements clinical pathways	Yes	Yes	Yes	Yes	Yes
19	Agrees to report outcomes data	*NSQIP Participating Centers*: ACS NSQIP & ACS BSCN *Non-NSQIP Participating Centers*: ACS BSCN	*NSQIP Participating Centers*: ACS NSQIP & ACS BSCN *Non-NSQIP Participating Centers*: ACS BSCN	ACS BSCN	ACS BSCN	ACS BSCN
20	Has an established quality improvement program	Yes	Yes	Yes	Yes	Yes
21	Reviews outcomes data as part of the facility's surgeon credentialing process	Yes	Yes	Yes	Yes	Yes
22	Multidisciplinary group reviews candidates in the patient selection process	Yes	Yes	Yes	Yes	Yes
23	Patient education on pre- and postoperative expectations through the distribution of printed handouts	Yes	Yes	Yes	Yes	Yes
24	Extensive explanation of informed consent and assent	Yes	Yes	Yes	Yes	Yes
25	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
26	Protocol in place for patient discharge including instructions for activity, diet, wound care, and symptoms of complications	Yes	Yes	Yes	Yes	Yes
27	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
28	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 service agreement with a designated inpatient facility within a 30-minute proximity with a fully staffed and medically equipped Emergency Room, Intensive/Critical Care Unit, and Dialysis Unit are readily available throughout the year for patient transfer.

Abbreviations: AOA, American Osteopathic Association; AAAHC, Accreditation Association for Ambulatory Health Care; DNV, Det Norske Veritas; ABS, American Board of Surgery; AOBS, American Osteopathic Board of Surgery; RCPSC, Royal College of Physicians and Surgeons of Canada; 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

Amy Robinson-Gerace
BSCN Program Manager
Phone: 312/202-5443
E-mail: agerace@facs.org

Mona McDougall
BSCN Program Coordinator
Phone: 312/202-5210
E-mail: mmcdougall@facs.org

Barbara Epps
BSCN Program Coordinator
Phone: 312/202-5222
E-mail: bepps@facs.org

Contact
American College of Surgeons
Bariatric Surgery Center Network
633 North St. Clair Street
Chicago, IL 60611-3211
E-mail: bscn@facs.org
Fax: 312/202-5011
www.acsbscn.org