



# The American College of Surgeons **Bariatric Surgery Center Network:** Establishing standards

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**P**atient demand for bariatric surgical services has been exponential, but meeting that demand has not kept pace with the epidemic of obesity (see Figure 1, page 22).<sup>1</sup> Obesity is defined as a body mass index (BMI) greater than 30 kg/m<sup>2</sup>, and weight loss surgery is reserved for patients with comorbid conditions and a BMI greater than 35 or a BMI of 40 alone. Severe obesity is defined as having a BMI  $\geq$  40. In 2003, more than 110,000 bariatric operations were performed in the U.S.<sup>2</sup> With estimates of 11.5 million patients meeting medical necessity for weight-loss surgery, millions of potential patients may not have access to care.<sup>3</sup> Without weight-loss surgery, severe obesity treated by diet and exercise carries its own high mortality.<sup>4-6</sup>

In response to the epidemic of obesity, many surgeons are adding weight-loss surgery (see Figures 2 and 3, page 23) to their practices and bariatric centers are emerging to meet the de-

mand for this operation, for which there are long waiting lists. Societies, licensing boards, and governmental agencies have published guidelines to standardize care and encourage hospital investment in its infrastructure for their patients of size. The Betsy Lehman Center for Patient Safety and Medical Error Reduction convened an expert panel in Massachusetts to establish best practices for weight loss surgery ([www.mass.gov/dph/betsylehman/panel\\_summary.htm](http://www.mass.gov/dph/betsylehman/panel_summary.htm)).<sup>2</sup> The American Society for Bariatric Surgery (ASBS) recognized the importance of establishing “centers of excellence” and established a program for accreditation of surgeons and facilities based on volumes, personnel, and infrastructure.<sup>7</sup> The ASBS endorsed a not-for-profit corporation with a board representing surgeons, industry, and insurance providers to oversee the new corporation. Site visits are conducted by nurses. The best programs would be recognized based on initial criteria of hospital volume and surgeon

experience. Lower-volume hospitals could not meet the centers of excellence criteria.

The American College of Surgeons had already recognized the importance of surgeons accrediting surgeons. The ACS had established the Hospital Standards Committee, which became the Joint Commission on Accreditation of Healthcare Organizations (now called The Joint Commission) in 1951. Later the ACS established the accreditation of trauma centers and cancer centers. The ACS established a Bariatric Surgery Center Network (BSCN) Advisory Committee in 2003 to set criteria for accreditation of bariatric surgery centers using the already existing programs for trauma and cancer centers as suggested templates. Key concepts were that surgeons alone, and not industry or nonsurgeons, needed to have oversight of the accreditation process; the professional society—not a separate corporation—should oversee the process; and although institutions, facilities, and programs needed rigorous accreditation, surgeon expertise would be better assessed by local hospital credentialing systems already in existence. The goal was to be inclusive and to use best-practice guidelines to improve patient safety across programs. Central to the goal of the ACS was a database that could be verified, to ensure patient outcomes did not deviate from risk-adjusted benchmarks. Maintenance of accreditation would be based on meeting these benchmarks.

The American College of Surgeons Board of Regents formally approved the BSCN to accredit hospitals in 2005. The standards established for the American College of Surgeons BSCN Accreditation Program delineate four levels for accreditation of inpatient facilities—identified as levels 1a, 1b, 2a, and 2b—and outpatient surgical care facilities, identified as “outpatient.”

High-quality surgical care requires documentation of reliable outcome measurements. Level 1a and 2a centers will use the ACS National Surgical Quality Improvement Program (ACS NSQIP) adapted for bariatric surgery, requiring a trained surgical clinical nurse reviewer to collect and submit the required ACS NSQIP data. These centers will have access to benchmark reports containing national aggregate data and individual facility data to assess patterns of care and outcomes relative to national norms. Level

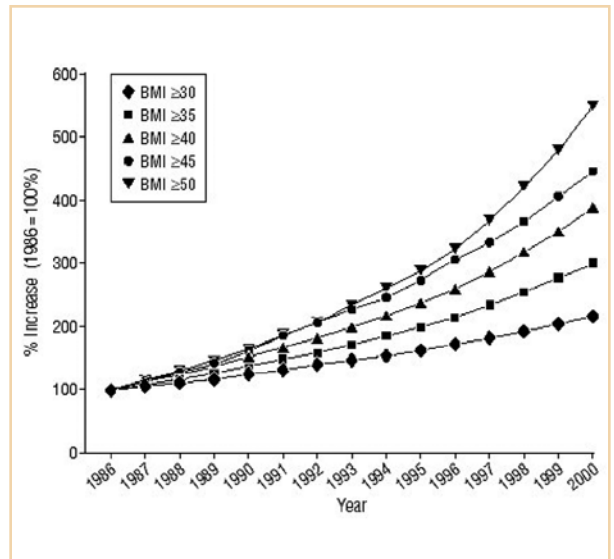


Figure 1. Prevalence of morbid obesity in the U.S. by body mass index.<sup>1</sup>

1b, 2b, 2-new, outpatient facilities, and outpatient-new will report outcomes data to the ACS bariatric surgery database for accreditation purposes only. A designated and trained nonsurgeon of the bariatric surgery team will enter the data using the ACS’ established protocol. All centers must capture 100 percent of bariatric cases in their data collection.

### Level 1a and 1b centers

Level 1 centers will provide complete care, with resources devoted to bariatric surgery. These hospitals can manage the most challenging and complex patients with optimal opportunity for safe and effective outcomes. These centers will engage all levels of obesity and standards of care for weight loss operations, ages, comorbid conditions, and reoperations. They will have high-volume practices of 125 or more weight-loss operations annually, with at least two credentialed and experienced bariatric surgeons, each performing a minimum of 100 weight-loss operations in the previous 24 months. These centers may apply for level 1 accreditation after providing bariatric surgery services for more than one year.

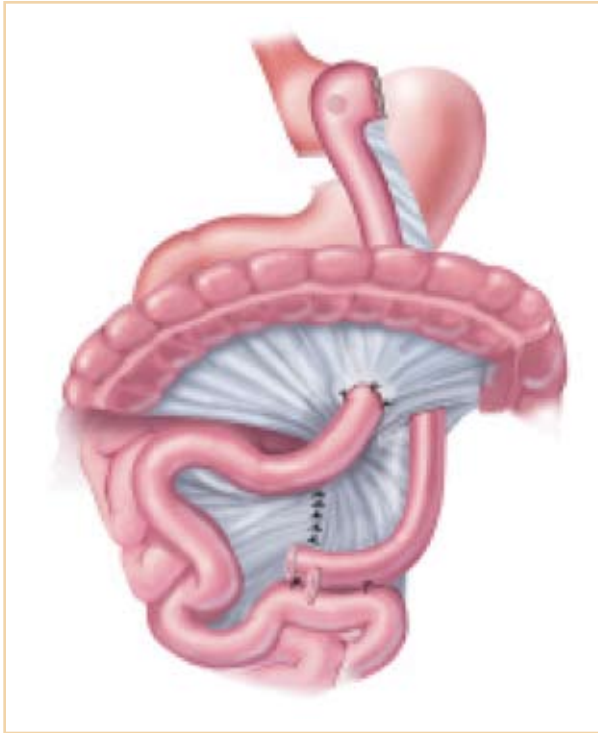


Figure 2. Laparoscopic gastric bypass.

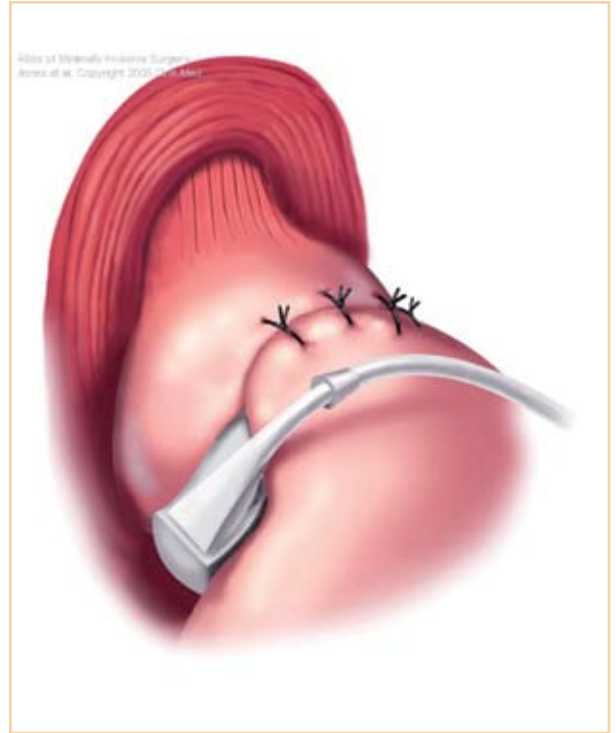


Figure 3. Laparoscopic adjustable gastric band.

Source: Jones DB, Maithel SK, Schneider BE. *Atlas of Minimally Invasive Surgery*. Woodbury, CT: Ciné-Med, Inc.; 2006. Used with permission.

### **Level 2a and 2b centers**

Recognizing that high-quality surgical care occurs in centers that don't have a high volume of cases, the ACS will designate certain facilities as level 2 centers. These centers will provide high-quality care to a lower volume of patients—25 or more weight-loss operations annually, with one or more credentialed and experienced bariatric surgeon performing a minimum of 50 weight-loss operations in the previous 24 months. Level 2 bariatric surgery centers are not approved for operations on high-risk patients, such as men with a BMI of 55 or higher, women with a BMI of 60 or greater, or any nonambulatory patients or elective revisional operations. These centers may apply for level 2 accreditation after providing bariatric surgery services for more than one year.

In February 2006, the Centers for Medicare & Medicaid Services (CMS) tied reimbursement for bariatric surgery to already-existing patient-qualification criteria in addition to the requirement that the center be approved as a level 1 ACS center or ASBS-accredited program. In Massachusetts, Blue Cross Blue Shield broadened reimbursement to include ACS level 2a centers reporting excellent patient outcomes. It is hoped that CMS will eventually amend its decision and provide reimbursement for level 2 centers as well.

### **Outpatient centers**

Outpatient centers will provide the application and adjustment of laparoscopic gastric bands. These centers will perform 50 or more weight-loss operations annually, with at least one

*continued on page 26*

# ACS-accredited bariatric centers

## Level 1 centers

### Alabama

University of Alabama at Birmingham Hospital, Birmingham, AL (Level 1a)  
Effective 12/7/06–12/7/09

### California

Community Medical Center–Clovis, Clovis (Level 1b)  
Effective 6/26/06–6/26/09

Cedars-Sinai Medical Center, Los Angeles (Level 1a)  
Effective 6/20/06–6/20/09

### Connecticut

Danbury Hospital, Danbury (Level 1a)  
Effective 5/5/06–5/5/09

### Florida

Cleveland Clinic Florida, Weston (Level 1a)  
Effective 10/19/06–10/19/09

### Illinois

Evanston Northwestern Hospital, Evanston (Level 1b)  
Effective 1/26/06–1/26/09

### Iowa

Grinnell Regional Medical Center, Grinnell (Level 1a)  
Effective 10/19/06–10/19/09

### Michigan

Hurley Medical Center, Flint (Level 1b)  
Effective 4/14/06–4/14/09

### Minnesota

Mayo Clinic–St. Mary's Hospital, Rochester (Level 1a)  
Effective 10/23/06–10/23/09

### Massachusetts

Beth Israel Deaconess Medical Center, Boston (Level 1a)  
Effective 2/17/06–2/17/09

Brigham and Women's Hospital, Boston (Level 1a)  
Effective 8/14/06–8/14/09

Boston Medical Center, Boston (Level 1b)  
Effective 12/19/06–12/19/09

Massachusetts General Hospital, Boston (Level 1a)  
Effective 10/23/06–10/23/09

Newton-Wellesley Hospital, Newton (Level 1a)  
Effective 10/26/06–10/26/09

UMass Memorial Medical Center–Memorial Campus, Worcester (Level 1b)  
Effective 7/27/06–7/27/09

### New Jersey

Hackensack University Medical Center, Hackensack (Level 1a)  
Effective 12/8/06–12/8/09

Morristown Memorial Hospital, Morristown (Level 1a)  
Effective 1/25/07–1/25/10

### New York

Albany Medical Center, Albany (Level 1b)  
Effective 6/2/06–6/2/09

Lutheran Medical Center, Brooklyn (Level 1b)  
Effective 11/8/05–11/8/09

New York-Presbyterian Hospital/Columbia University Medical Center, New York (Level 1a)  
Effective 6/14/06–6/14/09

New York-Presbyterian Hospital/Weill Cornell Medical Center, New York (Level 1a)  
Effective 8/4/06–8/4/09

St. Luke's-Roosevelt Hospital Center, New York (Level 1b)  
Effective 10/11/06–10/11/09

Highland Hospital, Rochester (Level 1b)  
Effective 8/30/06–8/30/09

### Ohio

Cleveland Clinic, Cleveland (Level 1a)  
Effective 12/1/06–12/1/09

### Oklahoma

Saint Francis Hospital, Tulsa (Level 1b)  
Effective 10/23/06–10/23/09

## Oregon

Oregon Health & Science University, Portland  
(Level 1a)  
Effective 6/27/06–6/27/09

## Pennsylvania

Geisinger Medical Center, Danville (Level 1a)  
Effective 1/26/07–1/26/10

Western Pennsylvania Hospital, Pittsburgh  
(Level 1b)  
Effective 10/16/06–10/16/09

## Vermont

Fletcher Allen Health Care, Burlington (Level 1b)  
Effective 6/9/06–6/9/09

## Virginia

University of Virginia Health System, Charlot-  
tesville (Level 1a)  
Effective 7/12/06–7/12/09

Sentara Norfolk General Hospital, Norfolk (Level  
1a)  
Effective 9/29/06–9/29/09

## Washington

University of Washington Medical Center, Seattle  
(Level 1a)  
Effective 12/5/06–12/5/09

## Wisconsin

Theda Clark Medical Center, Neenah (Level 1b)  
Effective 1/27/06–1/27/09

## Level 2 centers

### Maryland

Harford Memorial Hospital, Havre de Grace  
(Level 2b)  
Effective 12/21/06–12/21/09

## Outpatient centers

### Texas

Surgery Center of Richardson, Richardson  
Effective 6/21/06–6/21/09

## ACS Bariatric Surgery Center Network Advisory Committee

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credentialed and experienced bariatric surgeon performing a minimum of 50 primary weight-loss operations annually. These facilities must provide bariatric surgery services for more than one year before applying for outpatient accreditation.

### ***Level 2-new centers***

At an ACS BSCN Advisory Committee meeting in November 2006, committee members approved an additional level of accreditation, level 2-new, for more recently established centers. New programs can apply for accreditation as a level 2-new center without having to provide bariatric services for more than one year, but 25 weight-loss operations within the last 24 months are required. New centers submit outcomes quarterly and can apply for level 1 status after one year with adequate facility and surgeon volumes and all other level 1 standards having been met.

### ***Outpatient-new centers***

At its meeting in April 2007, the committee approved an additional level of accreditation for newly established outpatient facilities. An outpatient-new center may apply for accreditation after performing a minimum of 25 laparoscopic gastric bands. The program must meet all standards for outpatient facilities with the exception of time and volume requirements. After one year of accreditation, these centers may convert to outpatient center status.

### ***Grandfather clause***

The ACS BSCN program understands that established bariatric surgeons will relocate, and as such, surgeons with 300 lifetime cases will be considered bariatric surgeons for accreditation purposes. Moreover, fellows completing a formal minimally invasive surgery/bariatric fellowship should be credited for cases performed during fellowship training upon entering practice. However, such cases are not applicable to an institution other than the training center. Certification in fundamentals of laparoscopic surgery is recommended for newly trained laparoscopic surgeons.

### ***The ACS bariatric surgery database***

Level 1b, level 2b, and outpatient bariatric surgery centers will report their outcomes data to the ACS bariatric surgery database using

a Web-based data-entry system. A designated trained nurse or other nonsurgeon of the bariatric surgery service will enter the data using the established protocol. The entered data will be subjected to quality control. The data will be entered into the database encrypted and deidentified to protect the confidentiality of the patients, the hospital, the outpatient facility, and the surgeons. When the hospital or outpatient facility receives the data reports, staff can identify the patients and surgeons. The hospitals and outpatient facilities will receive annual data reports. Center verification visits will include audits of the data, which include chart reviews. These data do not have the same rigor as ACS NSQIP and are not risk adjusted; furthermore, they will not be used to make comparisons or for research because of the lack of rigor. These data will only provide a center's outcomes to the ACS for accreditation.

### ***Data monitoring***

- *Level 1a and 2a centers*

Level 1a and 2a centers, which are ACS NSQIP participants, can monitor their data on a 24/7/365 basis using the ACS NSQIP Web site. They can compare their data with the average of the other centers in the program. These centers will receive a semi-annual report of their risk-adjusted outcomes in confidential ranking with other center programs. These data will also undergo confidential review by the ACS NSQIP Advisory Committee and the ACS BSCN Advisory Committee. If these reviews reveal trends or variances of concern, the concerns will be communicated to the hospital chief executive officer (CEO), the surgeon director, and the program coordinator. Each ACS NSQIP Center will have interrater reliability visits from a trained, experienced surgical clinical nurse reviewer. This process involves a medical record review to assess the reliability of the submitted data and the variability of data collection and submission.

- *Level 1b, 2b, and outpatient facilities*


Level 1b, 2b, and outpatient facilities are participants in the ACS BSCN database. The hospital CEO, the bariatric surgery director, and the bariatric surgery coordinator will receive a report of their non-risk-adjusted outcome data annually. The ACS BSCN Advisory Committee will review

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each hospital's deidentified data annually. If these reviews reveal trends or variances of concern, the concerns will be communicated in a special report to the hospital CEO, the bariatric surgery director, and the bariatric surgery coordinator.

### **Finding out more**

To learn more about the necessary physical resources, human resources, clinical standards, surgeon standards, data-reporting standards, and verification/approvals processes required for the designation of American College of Surgeons bariatric surgery centers, log on to the ACS Web site, [www.facs.org](http://www.facs.org), and click on the link to the program in the left-hand column of the home page. Applications can be downloaded. At the time of application submission, established centers that have been in operation for more than two years will be asked to provide data for the previous two years. Facilities that have been in operation for less than two years will be asked to provide all their data. The applying center's outcomes data are to be reported at 30 days postoperatively or in-house acute care. After successful review of an application, a site visit is scheduled. The committee reviews findings and accreditation is posted. For further inquiries, contact the ACS BSCN directly at [BSCN@facs.org](mailto:BSCN@facs.org).

Recognition as an accredited member of the ACS BSCN demonstrates a program's commitment to the highest standards of care by the bariatric surgeons, allied health team, and hospital. Obesity remains a major health problem, and society needs to do more to prevent and treat the disease. The ACS BSCN establishes guidelines to ensure an infrastructure, multidisciplinary program, and patient preparation process to promote best practices and patient safety. 

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