Part 3: The American Society for Metabolic and Bariatric Surgery Bariatric Surgery Center of Excellence Bariatric Quality Improvement Program (ASMBS BSCOE/BQIP) – Proposal for a New Quality Matrix

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"The ASMBS has embarked on an evaluation of our current BSCOE program. Throughout the last 10 months, many of our colleagues have been working in ASMBS committees and sub-committees to evaluate different parts of the current program and make proposals for an evolution of the program. Those proposals are now ready for member comment and input. The third installment details a new quality matrix. Once all of the information has been presented we will have a survey/comment period so that you can give the leadership your feedback."

Robin Blackstone, MD, ASMBS President

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Introduction

The existing ASMBS BSCOE has 10 requirements for achieving full approval. The new proposed ASMBS BSCOE/BQIP program will focus on continuous quality improvement as well as an outcome based composite quality measure. A new quality matrix needs to be implemented that maximizes the autonomy to the surgeons/programs to evaluate their data and solve problems on the local level with the resources of their own facility and practice. The proposed new quality matrix below has four goals:

1) Preserve those elements of structure and process that are proven to result in improved patient safety and add a comparative and predictive composite quality measure for outcomes.
2) Allow programs/surgeons to participate from the beginning of their experience so that the program grows in the best model.
3) Provide opportunity for programs to develop as new surgeons/fellows enter the field or as established surgeons want to establish new programs.
4) Include elements that give programs an advantage with payors that establish a mechanism to use quality as a pay for performance reimbursement strategies.

#1 - Institutional Commitment to Excellence	#2 - Surgical Experience and Volume
#3 - Designated Medical Director	#4 - Responsive Critical Care Support
#5 - Appropriate Equipment and Instruments	#6 - Surgeon Dedication and Qualified Call Coverage
#7 - Clinical Pathways and Standardized Operating Procedures	#8 - Bariatric Nurses, Physicians Extenders and Program Coordinator
#9 - Patient Support Groups	#10 - Long term patient Follow-up, including BOLD

Table 1: The 10 Requirements of an ASMBS BSCOE as established in 2004

As detailed in Part 2 of this series, throughout time, the Bariatric Surgical Review Committee (BSRC) has been called upon to interpret the standards for individual programs/surgeon situations; some requirements have become increasingly restrictive and prescriptive of surgeon/facility behavior. Some requirements were based on best surgeon opinion and their relationship to quality is unknown. The proposed new quality matrix below looks to address both the volume and interpretation issues, but most importantly provides a safe background for the ongoing accreditation of quality programs in bariatric surgery and the development of new programs.

The Proposed New Matrix

The proposed new matrix for the ASMBS BSCOE/BQIP has seven requirements.

#1 - Institutional Commitment to Excellence	#2 - Surgical Experience and Volume

#3 - Designated Medical Director	#4 - Responsive Critical Care Support
#5 - Appropriate Equipment and Instruments	#6 - Qualified Call Coverage
#7 - Clinical Pathways, Standardized Operating Procedures, Long-Term Follow-up Care and Support Groups	

Table 2: The proposed ASMBS BSCOE/BQIP Requirements

Each of these requirements is divided into three levels including mandatory, recommended and best practice. The requirements with the mandatory, recommended and best practice aspects are provided below in detail. The mandatory requirements are necessary to participate in the program. Programs/surgeons may be at different places in this matrix at different times in the development of a program and may not have the resources to provide all of these aspects of care, especially if volume is low. However, they will always have to meet the composite measure standard. Although volume often determines the depth of resources the program can provide to the patient, a program can still provide high quality of care as measured by the risk and reliability adjusted composite quality measure. Programs who do not meet the minimum composite measure standard will be eligible to engage in an intensive Continuous Quality Improvement (CQI) team site visit, to help them realign their program to achieve that goal.

1) Institutional Commitment to Excellence

Mandatory	**Recommended**	**Best Practice**
Agreement to participate in ASMBS BQIP	Bariatric Committee	Bariatric Service line
Surgeon must be a member of ASMBS, ACS, SAGES or SSAT or their national surgical society	Surgeon is a regular member or international member of ASMBS	Surgeon and integrated health staff are ASMBS members
Monthly data abstraction by designated data collection staff member	Monthly data abstraction by designated data collection staff member	Dedicated resource for data abstraction
Participation in regular (up to annually) data validation site visits. New programs will require 3 month visit initially to evaluate database compliance, structure and process	Participation in regular (up to annually) data validation site visits	Participation in regular (up to annually) data validation site visits
ASMBS/ACS/SAGES credentialing guidelines in place	ASMBS/ACS/SAGES credentialing guidelines in place	ASMBS/ACS/SAGES credentialing guidelines in place
One facility representative must attend at least two quality improvement meetings annually such as ASMBS annual meeting, regional or state meeting (ASMBS and/or ACS State Chapter)	Surgeon representative attends at least two quality improvement meetings annually	Medical Director and Bariatric Coordinator attends at least two quality improvement meetings annually
Implement Safety protocols/National CQI process improvement projects approved by ASMBS Quality and Standards Committee for example: VTE Prophylaxis Protocol (Click here to go to a URL of the Michigan Bariatric Surgery Collaborative VTE project)	MIS/SAGES or W.H.O. safety checklist SCIP core measures for VTE prophylaxis and Antibiotic prophylaxis Implemented HCAHPS system for patient feedback	Program evaluates data and develops a CQI target and implements a process for improvement based on local experience Using HCAHPS to implement changes in behavior to improve the patient experience as part of the CQI process
Annual in-service on signs/symptoms of complications to specific units	Annual in-services for sensitivity training and patient transfer &	Annual in-services sensitivity training and patient transfer & mobilization

caring for the bariatric surgery patient	mobilization training to designated key personnel	training to all hospital staff and volunteers
Bariatric coordinator can be either administrative or healthcare personnel working at least part time in bariatric program	Bariatric coordinator is licensed healthcare personnel	Bariatric coordinator is a dedicated facility resource and has passed the Certification Bariatric Nursing Examination
Agreement to designate bariatric nurses and dietitians into program	Agreement to designate bariatric nurses and dietitians into program	Fully implemented physician extenders (PA/NP/RNFA/dietitians/etc.)
Designated bariatric surgery area in the hospital and office	Designated bariatric surgery area in the hospital and office	Designated bariatric surgery area in the hospital and office

Table 3: Institutional Commitment to Excellence

At the highest levels of the applicant medical staff and the institution's administration, an institutional commitment to excellence in the care of bariatric surgical patients as documented with an agreement to:

1) participate in the ASMBS BSCOE/BQIP with monthly data abstraction
2) attend a minimum of two quality improvement meetings annually (attendance is mandatory)
3) participate in regular (up to annually) data validation site visits
4) implement ASMBS/ACS/SAGES credentialing guidelines
5) implement safety protocols
    a. ASMBS-approved mandatory protocols as recommended by the ASMBS Clinical Issues Committee
    b. Surgical Care Improvement Project (SCIP) core measures
    c. MIS/SAGES or W.H.O. safety checklist at 100 percent compliance
6) utilize the national surgical society CQI program designated by the ASMBS Quality & Standards Committee and agreed to by ASMBS Executive Council
7) schedule annual in-service education program discussing the complications of bariatric surgery

Interpretive Notes

The applicant must sign an agreement to participate in the ASMBS BSCOE/BQIP and abstract data on a monthly basis. The institution will participate in regular site visits to validate data. The surgeon does not need to be an ASMBS member to participate in the program, but should belong to a national surgical society with ethics standards. "Best Practice" requires that all surgeons in the program and the integrated health staff are ASMBS members. Hospitals will agree to prepare, to the best of their ability, cross-organizational commitment to bariatric surgical care, from the highest levels of the medical staff to the administration and all staff who come into direct contact with bariatric patients. Bariatric committees are recommended, but not mandatory. In a "Best Practice" environment, a center has a bariatric service line (core members required for service line are to be determined).

Regular Data Validation Site Visits: The goal of the ASMBS BSCOE/BQIP is to improve the quality of care for patients undergoing bariatric surgery. Participating hospitals submit data to the ASMBS BSCOE/BQIP clinical outcomes registry from a review of the medical records for all of their bariatric surgery patients on a monthly basis. This review is conducted for each patient at the end of the perioperative period (in-hospital/30 days after surgery) and includes information regarding preoperative clinical characteristics and conditions as well as perioperative clinical care and outcomes. For all centers already designated as a Center of Excellence (COE) by ASMBS or ACS, regular (as often as annually) site visits will occur to corroborate the fidelity of the data. New programs entering into a participation

agreement with ASMBS BSCOE/BQIP will require an initial three month site visit to confirm that the center is developing the necessary quality standards and is able to enter data in the national database. These site visits will be by bariatric surgeons who have been trained in data and site validation techniques on a regional basis.

Attendance to at Least Two Quality Improvement Meetings Annually: Regular reporting of high quality risk adjusted data to programs and surgeons is essential to the success of the ASMBS BSCOE/BQIP. The ASMBS BSCOE/BQIP participants must agree to meet at least two times per year to review and compare data with their risk-adjusted cohorts, and to develop and broadly implement strategies to improve bariatric care and outcomes at all sites. At least one facility representative (surgeon, bariatric coordinator, licensed healthcare professional) must attend at least two meetings annually, held at 1) ASMBS Annual Meeting and at an 2) ASMBS and/or ACS State Chapter Meeting(s). It is "Recommended Practice," but not mandatory, that a surgeon representative be present for two meetings annually. “Best Practice” requires that both the medical director and bariatric coordinator attend two meetings annually.

Credentials and Privileges: Hospitals must have defined bariatric surgery credentialing and privileging guidelines, as recommended by ASMBS/ACS/SAGES, which are separate from general surgery guidelines.

Safety Protocols: Hospitals must have fully implemented safety and quality improvement protocols prior to participating in the ASMBS BSCOE/BQIP. Hospitals must implement and document utilization of safety protocols recommended by the ASMBS Clinical Issues Committee, SCIP core measures describing antibiotic prophylaxis, VTE prophylaxis, glucose control, beta-blocker therapy, hair removal and temperature management. Hospitals must also implement and document utilization of either the MIS/SAGES or W.H.O. safety checklist at 100 percent of cases. Recommended and Best practice hospitals will have fully implemented the HCAHPS patient feedback system.

Designated Bariatric Surgery Area: hospitals must have a dedicated bariatric floor or designated cluster/group of beds maintained in a consistent area of the hospital.

In-service education: hospitals must also have ongoing, in-service education programs for the bariatric team that are well established and properly managed. These education programs must ensure a basic understanding of bariatric surgery including risks and benefits for all procedures and including concepts as well as the appropriate management and care of the bariatric patient. Recommended and best practice hospitals will have surgeons and integrated health staff certified in the ASMBS BSCOE/BQIP Continuing Medical Education (CME) *Understanding the Composite Measure and Quality Outcomes in Bariatric Surgery* course. The following in-services must be attended and documented by all applicable staff:

- **Signs and symptoms of postoperative complications:** in-service education must help ensure that those directly caring for bariatric patients are able to recognize the potential signs and symptoms of common bariatric surgery complications (e.g., pulmonary embolus, anastomotic leak, infection and bowel obstruction) so the patient can be managed promptly. Hospitals must also have a system in place to ensure the ongoing competencies of staff in recognizing these signs and symptoms. The minimum frequency required for signs and symptoms of postoperative complications is annually for all relevant staff that has direct contact with bariatric patients.
- **Sensitivity training:** in-service education must support a culture where staff members are prepared to manage severely obese patients with understanding and compassion and appreciate the burdens of the co-morbidities of severe obesity.
- **Patient transfer and mobilization:** in-service education must address the safe transfer and mobilization of severely obese patients, which is for the benefit of the patient as well as the staff.
- **Patient education and informed consent process documented**

The minimum frequency required for sensitivity training and patient transfer and mobilization training is once every three years for all relevant staff. However, most BSCOE hospitals provide this training every year and other programs are encouraged to do so as well. "Recommended Practice" requires training in these two areas upon hiring for all new employees who will have direct contact with bariatric patients.

“Best Practice” requires providing all three in-services annually to all hospital staff.

Bariatric Program Coordinator: bariatric surgery programs must have a designated bariatric coordinator who supervises program development, patient and staff education, ongoing compliance and multidisciplinary team meetings. This person serves as the liaison between the hospital and surgical practice(s). The coordinator also typically serves as the primary ASMBS BSCOE/BQIP contact person (along with the Data Administrator for training and data entry). For initial entry into the ASMBS BSCOE/BQIP, any administrative or healthcare personnel can act as the bariatric coordinator. "Recommended Practice" requires that a licensed healthcare professional occupy the bariatric coordinator position fulltime if the bariatric program handles more than 150 bariatric surgeries annually. The bariatric coordinator position can be part-time if the program performs less than 150 procedures annually. “Best Practice” requires the bariatric coordinator to be a nurse who has passed the Certified Bariatric Nurse (CBN) exam.

2) Surgical Experience and Volumes

Mandatory	Recommended	Best Practice
Volume is part of the composite quality measure		
Risk & Reliability adjusted outcomes measures will be used to determine how the program compares to its peers and level of performance requirements. All current BSCOE programs qualified through a volume requirement and will be required to meet acceptable performance standards based on the composite measure by January 2013.		
Bariatric surgeon can be eligible for certification or Board Certified by the ABS or in their respective country by their own certifying body	Bariatric surgeon is Board Certified by the ABS or in their respective country by their own certifying body and participates in Maintenance of Certification	Bariatric surgeon is Board Certified in the U.S. by ABS, or in their respective country by their own certifying body and is participating in Maintenance of Certification if a U.S. surgeon

Table 4: Surgical Experience and Volumes

Each applicant surgeon must perform the required number of bariatric procedures in order to obtain credentials at the applicant institution(s) based on the joint ASMBS/ACS/SAGES credentialing guidelines. To participate in the ASMBS BSCOE/BQIP, the surgeon must be (the term board eligible is not acceptable to use according to the ABS) eligible for certification or board-certified in general surgery, or hold credentials by an ASMBS approved specialty certification that is based on experience, and demonstrates good standing, licensing and fellowship.

Interpretive Notes

Where volume was required in the previous ASMBS BSCOE program, there is no volume requirement for hospitals and surgeons to participate in the ASMBS BSCOE/BQIP, other than what is required by hospital policy to maintain credentials

at the applicant facility. Composite risk and reliability adjusted outcome measures will determine how the program compares to its risk-adjusted cohorts and programs can develop individualized quality improvement plans based on the data results. During the early stages of implementing the composite measure, no baseline performance parameters will be determined. However, it is anticipated that by January 2013 level of performance parameters will be determined and programs must perform in a satisfactory manner in order to continue in the ASMBS BSCOE/BQIP. It is anticipated that programs will need to perform in the top four out of five quintiles to meet performance standards. However, performance parameters and standards may be either higher or lower based on the results of a comprehensive review of the data.

The surgeon must be eligible for certification or board-certified as a general surgeon by the American Board of Surgery (ABS), American Osteopathic Board of Surgery (AOBS), or Royal College of Physicians and Surgeons of Canada (RCPSC). "Best Practice" requires that all surgeons in the program are board certified. Special groups like pediatric surgeons and international surgeons/programs will be addressed in a later segment however it is expected that they can qualify for the ASMBS joint program similar to other surgeons/programs.

The following procedures are approved procedures in good standing with ASMBS, qualify for data input into the ASMBS BSCOE/BQIP and will be utilized to generate your composite quality score:

- Gastric bypass: short- or long-limbed, transected or not transected, banded or not banded
- Gastric banding: includes procedures in which the Allergan LAP-BAND® is used in patients with Class I obesity (BMI of 30-35) and at least one co-morbidity
- Duodenal switch
- Biliopancreatic diversion
- Sleeve gastrectomy

The following additional procedures, including investigational procedures, whether open, laparoscopic or endoscopic, also qualify for data input into ASMBS BSCOE/BQIP when performed on bariatric surgery patients:

- Gastric plication, with or without banding
- Emerging technology procedures (as determined by the Emerging Technology Committee and approved by ASMBS)
- Repairs of colonic mesentery and Petersen’s hernias as well as hernias forming around an adhesion
- Any gastric band revision or replacement that involves both repositioning and resuturing
- Removal of a slipped or eroded gastric band
- Replacement of a slipped or eroded gastric band
- Gastrojejunostomy repair/revision
- Enteroenterostomy repair/revision
- Lengthening of the common channel
- Lengthening of the Roux limb
- Gastric pouch revision
- Conversion to another primary bariatric procedure recognized by the ASMBS (see list above)
- Reversal of gastric bypass, vertical banded gastroplasty, intestinal bypass,
- Biliopancreatic diversion and duodenal switch procedures
- Re-sleeving for weight gain or sleeve dilation
- Removal of a Fobi/Capella band with adhesions
- Revision or repair of a perforated marginal gastrojejunal ulcer
- Gastric band port revisions including port/tubing removal, replacement and repositioning
- Removal of a gastric band for reasons other than slippage or erosion

- Gastric stoma plication
- Therapeutic endoscopic procedures used to dilate strictures, stent placements, control of hemorrhage
- Partial or total gastrectomy
- Repairs of inguinal, incisional, hiatal, umbilical and port-site hernias
- Diagnostic endoscopic procedures
- Any additional procedure that is part of a "Revisional" bariatric procedure

All bariatric surgical procedures performed by general surgeons, who *are not* credentialed in bariatric surgery, *will* be entered into the ASMBS BSCOE/BQIP database. Documentation of each hospital and surgeon procedure is required to enable data validation and a medical chart review.

3) Designated Medical Director

Mandatory	**Recommended**	**Best Practice**
Medical Director is not required, but program should have designated bariatric surgeon champion	Medical Director can be any physician within bariatric program	Medical Director must be active bariatric surgeon, and position must be fully integrated into hospital organizational framework

Table 5: Designated Medical Director

Where a medical director was required in the previous ASMBS BSCOE program, a designated medical director is not required for initial participation in the ASMBS BSCOE/BQIP; however, it is required that the facility maintains a designated bariatric surgeon champion who participates in the relevant decision-making administrative meetings of the institution. In addition, it is the intention that the surgeon champion will be involved with surgical quality in general and use the training and expertise developed by taking a leadership role in the bariatric quality improvement program to enhance surgical quality in general in the facility.

Interpretive Notes
Hospitals must have a designated bariatric surgeon champion who participates in meetings to ensure that bariatric related decisions are addressed in a comprehensive manner. Discussions held during these regularly scheduled meetings must be documented through minutes that demonstrate the surgeon champion's involvement in key program decisions. The surgeon champion must be a bariatric surgeon who actively addresses medical staff, nursing, administration, central supply, operating room personnel and business issues related to the delivery of bariatric surgical care. They must also run an organized and structured department of bariatric surgery.

Although a medical director position is not required for initial participation in the ASMBS BSCOE/BQIP, "Recommended Practice" requires that a hospital appoint a medical director. The medical director can be any physician (surgeon or non-surgeon) working in the bariatric program. The surgeon medical director does not need to be actively performing bariatric procedures.

"Best Practice" requires an active bariatric surgeon as the medical director, a fully integrated position within the hospital organizational framework. The medical director position must be official and appointed through the facility's standard administrative and medical staff process, and cannot be self-appointed. Of note, two co-medical directors can fill the position.

4) Responsive Critical Care Support

Mandatory	Recommended	Best Practice
Critical personnel available within 30 minutes: • Anesthesia/CRNA	Critical personnel available within 30 minutes • Physician capable of providing critical care • Endoscopist	Critical personnel available at all times • Board-Certified Critical Care Physician • Interventional Radiologist o Abscess drainage o IVC filter
ACLS qualified physician or physician extender available 24/7 (Code Team)	ACLS qualified physicians available 24/7	Rapid Response Team available
Written transfer agreements implemented	ICU with physician capable of providing critical care	Hospital with full critical care services, not requiring transfer (ICU 24/7)
Ability to stabilize and transfer patient to higher level of care		

Table 6: Responsive Critical Care Support

The applicant hospital maintains, within 30 minutes of request, staff of the various consultative services required for the care of bariatric surgical patients including the immediate availability of an advanced cardiac life support (ACLS) qualified physician or physician extender on-site who can perform patient resuscitations.

Interpretive Notes

If a bariatric surgery patient requires critical care, hospitals and their associated surgeons must ensure that they receive appropriate care.

Consultants: hospitals must maintain – and identify by name – on staff, a full complement of consultative services and equipment required for the care of patients who undergo bariatric surgery.

For initial participation in the ASMBS BSCOE/BQIP, the minimum requirement includes the following:

- **ACLS qualified physician or physician extender must be onsite 24/7.** This ensures that a qualified provider is able to perform patient resuscitations at any time in cases where anesthesia is not being administered. Of note, this coverage may be provided by a senior resident who is ACLS certified. Hospitals with an emergency department can fulfill this requirement with a certified emergency room physician, as long as the hospital's policies dictate that this physician will be available at all times.
- **Anesthesiologist or certified registered nurse anesthetist (CRNA)** who supervises anesthesia delivery on all bariatric surgery patients and is physically present while any of these patients are anesthetized.
- **Ability to stabilize patients and transfer to higher level of care:** Hospitals that *do not* have an ICU on-site must be able to support critical care delivery. They must have ventilators and hemodynamic monitoring equipment on-site so that qualified staff members are able to perform any necessary patient resuscitation. Full-time staff with experience that can support the management of a critically ill patient until the patient is sufficiently stable for transfer to a higher level of care (see recommended and best practices).
- **Written transfer agreement and surgeon privileges:** if applicable, hospitals and facilities must have a written transfer agreement that details the transfer plan of bariatric surgery patients to other emergency or critical care facilities that is capable of managing the full range of bariatric surgery complications at all times. Facilities must have the staff and equipment needed for transferring severely obese patients to that inpatient facility.

The safe transfer of a bariatric surgery patient to the full-service facility must occur in less than one hour, from the time the transfer decision to the initiation of care at the accepting facility. Facilities must have adequate staff available to provide emergency support, including the time in transfer, until the patient's care is assumed by the receiving facility.

"Recommended Practice" requires that programs maintain an ICU and provide the following consultative services that are available within 30 minutes.

- ACLS-qualified *physician*, available onsite 24/7 (note that physician extender, which is appropriate for initial participation in the ASMBS BSCOE/BQIP, does not meet requirements for recommended practice)
- Anesthesiologist or CRNA as described above
- Physician capable of performing endoscopies to diagnose complications
- Physician capable of providing critical care to manage complications: the physician can be a surgeon, critical care physician/Intensivist, hospitalist, cardiologist or pulmonologist. Having an off-site intensive care unit (ICU) monitoring system (live video feed and remote vital sign monitoring) does not fulfill the need of having consultants physically on-site within 30 minutes.

"Best Practice" requires that programs maintain an ICU with rapid response teams and full critical care services that do not require transferring patients to another facility. The following in-house consultative services must be available at all times (24/7).

- ACLS-qualified *physician*, available onsite 24/7
- Anesthesiologist or CRNA as described above
- Physician capable of performing endoscopies to diagnose complications
- Board certified critical care physicians
- Interventional radiologist or other physician capable of performing IVC filter placement or percutaneous drainage of an intra-abdominal abscess

Hospitals must also be able to identify by name other leading consultant team members, including the cardiologist, pulmonologist, nutritionist/dietitian and psychiatrist/mental health provider. When applicable, this would also include an infectious disease specialist or nursing program manager.

5) Appropriate Equipment and Instruments

Mandatory	**Recommended**	**Best Practice**
Hospital calculates BMI for *every* admitted bariatric surgery patient	Full line of equipment as outlined in current COE requirement	Hospital calculates BMI for *every* admitted patient (not restricted to bariatric surgery patients)
Agreement to procure appropriate equipment for obese patient and policy for use of equipment in place according to BMI of the patient		
Restrict procedures according to equipment weight limits		

Table 7: Appropriate Equipment and Instruments

The applicant maintains a full line of equipment and instruments for the care of bariatric surgical patients including furniture, wheel chairs, operating room tables, floor-mounted or floor-supported toilets, beds, radiologic capabilities, surgical instruments and other facilities suitable for severely obese patients. Hospitals must participate in the *Know your BMI* campaign by calculating and including BMI data on the charts for *every* bariatric surgery patient admitted.

Interpretive Notes

Initial participation in the ASMBS BSCOE/BQIP requires an agreement to procure equipment (need time frame) for obese patients and policies, according to the BMI of the patient, implemented regarding the use of the equipment. Bariatric procedures will be restricted according to weight limits of the existing equipment. It is encouraged that all participants advance to the recommended or best practice level.

"Recommended Practice" requires hospitals to have a full line of equipment and instruments for the care of patients who undergo bariatric surgery. This includes surgical/operating facilities and surgical instruments for the morbidly obese as well as appropriate radiological tables and facilities for evaluation, fluoroscopic technologies for band adjustments, medical imaging equipment for diagnostic purposes and ICU equipment. Additional required elements include chairs, beds, scales, floor-mounted or floor-supported toilets, wheelchairs, examination and operating room tables, crash carts and stretchers/litters that are strong enough and wide enough to accommodate the severely obese. Furniture and equipment must be able to accommodate patients that are within the patient weight limits established by the bariatric program. Weight capacities must be documented by the manufacturer's specifications, and this information must be readily available to relevant staff. Appropriate patient movement/transfer systems must also be located wherever bariatric surgery patients receive care. Personnel must be trained to use the equipment and, most importantly, capable of moving these individuals without injury to the patient or themselves (see Requirement 1 regarding in service education on patient transfers and mobilization). Hospitals and surgical offices *do not* need to change all of the equipment, furniture and instruments throughout the entire facility. This requirement only applies to those areas where patients undergoing bariatric surgery receive care. For some hospitals, this is a dedicated bariatric patient care area. For others, it occurs in several areas throughout the hospital. Radiology equipment with a weight capacity of more than 450 pounds (200 kilograms) has only recently become available. If the hospital's radiology equipment has a weight capacity less than 450 pounds, written policies and/or protocols referenced in clinical pathways must detail how patients who exceed the weight capacity are accommodated (see Requirement 7 for clinical pathways).

"Best Practice" requires the facility to maintain a labeling system for all equipment used for the care of the bariatric patient. In addition, ambulances serving the institution should also be equipped to manage bariatric surgery patients with appropriate stretchers, straps and transfer devices. Hospitals must also calculate and include BMI data on the charts for *every* patient admitted (not restricted to bariatric patients).

6) Qualified Call Coverage

Mandatory	Recommended	Best Practice
	At least one surgeon spending significant amount of time in field of bariatric surgery	At least one board-certified surgeon spending significant amount of time in field of bariatric surgery
No restriction on qualified call coverage, other than what is mandated by hospital policy	Non-bariatric surgeon coverage can be either Board-Certified or in the process of becoming Board-Certified	Participates in a 24/7 bariatric coverage call schedule
Agreement to develop protocol for non-bariatric surgeon coverage to undergo additional bariatric education	Non-bariatric surgeon completes ASMBS web-based modules describing procedures, complications and follow-up, or attend ABLS at annual ASMBS meetings	
No bariatric CME required for entry into ASMBS BSCOE/BQIP	4 bariatric CME credits annually	8 bariatric CME credits annually

Table 8: Qualified Call Coverage

There is no initial restriction on surgeon dedication or qualified call coverage, other than mandated hospital policy, to participate in the ASMBS BSCOE/BQIP. A bariatric program must have at least one surgeon champion who spends a significant amount of their time and efforts in the field of bariatric surgery. Programs must agree to develop protocols for non-bariatric surgeon coverage to undergo additional bariatric education. No bariatric surgery CME is required for initial entry into the ASMBS BSCOE/BQIP. Qualified call coverage and CME's are required for recommended and best practice levels.

Interpretive Notes
The ASMBS recognizes that it would be ideal to have a minimum of two bariatric surgeons participating in a 24/7 call schedule for coverage. This is an expected requirement of a best practice program; however, for a small to medium volume program or new program this is unrealistic. If a program is being covered by a non-bariatric surgeon part of the time, then that program should have in place appropriate transfer agreements with a best practice program that can receive a stabilized patient as needed.

"Recommended Practice" requires that at least one surgeon be dedicated to the field of bariatric surgery.

- **Board Certification Status:** Surgeons should be in the process of obtaining board certification or board-certified as a general surgeon by the American Board of Surgery (ABS), American Osteopathic Board of Surgery (AOBS), Royal College of Physicians and Surgeons of Canada (RCPSC) or other ASMBS approved credentialing body.
- **CME requirements:** Bariatric surgeons must have a minimum of 4 hours of Category 1 CME credits in bariatric surgery annually and show evidence of bariatric surgical expertise in accordance with ASMBS ethical guidelines.

Qualified Call Coverage: Surgeons must have qualified coverage by a colleague who can be responsible for the complete care of a bariatric patient – including the full range of complications associated with surgery of the severely obese – in the absence of the primary surgeon. It is encouraged that covering bariatric and general surgeons are board-certified by the ABS, AOBS, RCPSC, or other ASMBS approved credentialing body, and complete an ASMBS web-based module describing procedures, complications and patient follow-up, or attend the Advanced Bariatric Life Support (ABLS) course at the annual ASMBS meetings. All covering surgeons must be available on-site within 30 minutes. If a program is being covered by a non-bariatric surgeon part of the time, then that program should have in place appropriate transfer agreements with a best practice program that can receive a stabilized patient as needed.

"Best Practice" requires that at least one surgeon (and preferably two) be dedicated to field of bariatric surgery and board-certified and who participate in a 24/7 bariatric surgery call schedule.

- **Board Certification Status:** All bariatric surgeons must be board-certified as a general surgeon by the ABS, AOBS, RCPSC, or other ASMBS approved credentialing body.
- **CME requirements:** Bariatric surgeons must have a minimum of 8 hours of Category 1 CME credits in bariatric surgery annually and show evidence of bariatric surgical expertise in accordance with ASMBS ethical guidelines.
- **Qualified Call Coverage:** All covering surgeons are board-certified bariatric surgeons.

7) Clinical Pathways, Standardized Operating Procedures, Long-Term Follow-up Care and Support Groups

Mandatory	Recommended	Best Practice

Comprehensive pathway outlining the continuum of care of the bariatric surgery patient
 	
• Informed consent
• Patient education
  o Including follow-up care and support groups
• Perioperative care
  o Preoperative care, including anesthesia and airway management
  o Standardized Operative pathway
  o Postoperative care, including warning signs of complications
	Electronic Health Records	Multiple Clinical Pathways as designated by the ASMBS Clinical Issues Committee/Quality and Standards Committee and ASMBS Executive Council

	Computerized Physician Order Entry	Algorithms for preoperative clearances
	Long-term Follow-up protocols implemented	Maintain long-term follow-up (% follow-up is no longer required), with structured protocols, using bariatric surgery programs, bariatricians and/or primary care physicians
	Support groups every quarter; can be web-based or teleconference	In-house support groups every month run by healthcare professional

Table 8: Clinical Pathways, Standardized Operating Procedures, Long-Term Follow-up Care and Support Groups

The applicant utilizes clinical pathways and orders that facilitate the standardization of perioperative care for the relevant procedure. All surgeons must have standardized operative techniques outlined for each bariatric surgical procedure.

Interpretive Notes

Hospitals and surgeons must document and use clinical pathways and standardized orders to facilitate improved outcomes for the "uncomplicated patient" who undergoes bariatric surgery. The surgeon decides which bariatric operation(s) they will perform and what perioperative care will be. In turn, ASMBS BSCOE/BQIP requires that operations are performed in a standardized manner and perioperative care details are well documented and followed by the surgeon's team. Importantly, these standardized processes will also enable aggregate research on outcomes. Clinical pathways, a sequence of orders and therapies describing the routine care of the uncomplicated patient from initial patient evaluation through long-term follow-up, must be established and documented. They must cover the preoperative, intraoperative/surgical and postoperative phases of bariatric surgery patient care.

Initial participation in ASMBS BSCOE/BQIP requires a comprehensive clinical pathway that outlines the continuum of care of the bariatric surgery patient. The pathway should outline the following:

- informed consent process

- patient education, including plans to develop and implement long-term follow-up care and support groups if none exists. Although a support group facilitated by a licensed healthcare provider is encouraged, their presence is not required, including auxiliary or outlying meetings held in remote locations.
- perioperative care of the bariatric surgery patient
    - preoperative care, including anesthesia and airway management
    - standardized operative pathway, detailing the surgical technique for each surgeon and procedure
    - postoperative care, including standardized orders addressing warning signs of complications.

Hospitals must have designated surgical and nonsurgical nurses who serve bariatric surgical patients. Hospitals and surgeons must have nurses who provide education and care to bariatric surgery patients. These individuals must receive the ongoing in-service education in requirement #1.

"Recommended Practice" requires that long-term follow-up protocols and support groups be fully implemented. Support groups must be offered a minimum of every quarter, and can be web-based or teleconferenced. Organized and supervised support groups must be available for all bariatric surgery patients. Support groups can be organized by the practice and/or hospital, but the entity responsible for administering each support group must be clearly identified. Patients must have knowledge of their support group options. At a minimum, one primary in-person support group must be offered at least once a quarter and be facilitated or attended by a licensed healthcare provider. All patients must be notified about primary group(s). In addition, electronic medical records and computerized physician order entry is required.

"Best Practice" requires that programs provide long-term follow-up, either through the bariatric surgery program or through a structured relationship with an established bariatrician and/or the patient's primary care physician. The bariatric surgeon does not need to provide the follow-up personally; however, bariatric programs need to have mechanisms in place to follow the care, if it is delivered by another licensed or certified healthcare provider (such as the patient’s primary care physician), and ensure that the data is accurately entered into ASMBS BQIP in a timely fashion.

In addition, established clinical pathways must exist in a "Best Practice" environment. Clinical pathways can be documented in a variety of formats, including tables, algorithms/process maps and paragraph form. Nurses, physician assistants, residents, applicant surgeons and other applicable staff must be aware of the following suggested pathways.

- Anesthesia, including monitoring and airway management
- Perioperative care, including monitoring and airway management
- Deep vein thrombosis (DVT) management
- Management of warning signs of complications such as tachycardia, fever and hemorrhage
- Indications
- Contraindications
- Initial patient instruction
- Patient evaluation, including algorithms for preoperative system clearances
- Laboratory studies
- Imaging studies
- Patient education/consent
- Admission workup and evaluation
- Preoperative and postoperative nutrition regimen
- Wound care management
- Pain management

For compliance purposes, relevant data entry into ASMBS BQIP is required on all patients who undergo bariatric surgery after the date of ASMBS BSCOE/BQIP activation.

All in-person support group activities must be documented, including group location, meeting time, supervisor, curriculum and attendance (in compliance with HIPAA). Other activities, including web-based support groups, online forums, exercise, instruction and clothing sales should be noted, but do not require full documentation.

This concludes the proposal for a new quality matrix that is being considered for implementation for accreditation in the new ASMBS BSCOE/BQIP. Please move forward to segment 4, which details the proposal for a joint credentialing guideline. Later in the week, a survey will be sent out based on all four segments so that you can give us structured feedback as well as make comments.