

Bariatric surgery

Weighing the decision to become a bariatric center of excellence

Bariatric surgery received a boost in February 2006, when the Centers for Medicare and Medicaid Services (CMS) announced it would cover Medicare patients undergoing selected procedures. But patients must have the procedure at a facility accredited as a Bariatric Center of Excellence (BCOE) (sidebar, p 14).

Is it time for your hospital to offer bariatric surgery? If you already provide this service, should you become a BCOE? To answer those questions, you need to understand the level of commitment this service line demands.

"Bariatric surgery is a business you commit to," says DeNene Cofield, RN, BSN, CNOR. "It's not just another operation. Not since open-heart surgery has a single procedure had such an impact on every department of the hospital." Cofield is director of surgical services for Medical Center East in Birmingham, Ala, which performs about 25 bariatric surgeries each month.

It's not surprising that more hospitals are considering offering bariatric surgery and becoming a BCOE, given the prevalence of obesity in the US. More than 11 million people in this country are severely obese. In 2005, 60.5% of people in the US were overweight, 23.9% were obese, and 3% were extremely obese. These numbers have led to a rise in bariatric surgery. About 171,000 patients had bariatric surgery in 2005, up from 63,100 in 2002.

To become a BCOE, a facility first must have a strong bariatric surgery program. OR managers from bariatric centers shared their suggestions for deciding whether to offer this service line, setting up a program, and becoming a BCOE.

Planning and partnerships

Starting a program is demanding. Cofield recommends conducting a community needs assessment to help determine if the community can support a BCOE. Her hospital's assessment revealed a high prevalence of obesity and depression in its service area.

Next, forge strong partnerships with bariatric surgeons and obtain support from senior leadership. Once that is in place, establish a multidisciplinary bariatric committee and begin planning.

"The biggest thing to keep in mind," says Pamela Berg, RN, OR leader at United Hospital, St Paul, Minn, "is that the whole facility needs to be able to care for these patients: ICU, ED, the postanesthesia care unit (PACU), postop surgical floor, nutrition, medical imaging, waiting rooms, registration areas, anesthesia, [and more]." Psychologists and intensivists are also needed.

At United Hospital, the team includes bariatric surgeons, internists, radiologists, anesthesiologists, a dietician, exercise physiologist, pharmacists, nurses in the surgeon's office, representatives from nursing units, perioperative services, and the PACU nurses.

You would also need to hire a full-time bariatric surgery coordinator.

"The bariatric coordinator position is essential," says Linda Lund, RN, BSN, CNOR, director of perioperative services for Regional West Medical Center in Scottsbluff, Neb. "You don't want to go to all the work and put the patient through all the stress just to have them run into complications that could have been anticipated by the coordinator and bariatric team." Lund's hospital has been doing bariatric surgery since 2000.

Attitude is key: "You have to have surgeons and staff who love what they are doing, are committed to these patients, and see obesity as a health issue," says Ruth Darvell, RN, BA, postsurgical unit leader at United Hospital.

Factoring the volume

You need to determine projected volume and whether the numbers will cover expenses. "You have to do a large enough volume to become efficient and have strong outcomes," says Lund. "Just doing 2 to 3 procedures a month would not justify the investment in instruments, equipment, and staff."

To track volume, outcomes, and other data, a hospital needs software, and Berg recommends an electronic medical record. She says it was difficult to coordinate data from physicians' offices and the hospital, and it took time to work out a data collection system.

Cofield notes that bariatric surgery patients will want to return to the hospital for other services, so market share will increase.

Financial outlay

The biggest expense in starting a bariatric surgery center is equipment. Instruments are needed for laparoscopic and open surgical procedures. Additional equipment includes special OR tables, transfer aids, and wheelchairs.

Equipment needs extend beyond the OR. Because families of bariatric patients are frequently obese, special furniture is required in waiting areas, and extra-sized wheelchairs should be available. Every detail must be considered—toilets must be floor supported, not mounted on the wall.

Although the cost is significant, rising obesity levels mean more patients can benefit from the infrastructure established for bariatric surgery, and lessons learned apply to other patients. For example, Cofield notes that bariatric patients need double the dose of presurgical antibiotics, and this higher dosage is now used in other obese patients.

Attention to patients' weight affects the entire hospital. Staff become aware of weight limits for equipment. Cofield includes size limits in all capital purchases.

The bottom line? Cofield says, "If you don't have \$250,000 from day one, don't do the program."

Cloudy reimbursement picture

The CMS decision to cover bariatric surgery is encouraging, but reimbursement remains "hit and miss," according to Robin Ramsey, RN, BSN, CNOR, director of surgical services at Poudre Valley Hospital in Fort Collins, Colo. Surgeons there do 3 to 5 procedures a week. Both surgeons and hospitals have to work with insurance companies to try to obtain payment. Some third-party payers, such as Blue Cross in different states, reimburse according to specific criteria. However, a cash component is almost always required for payment. The hospital needs to examine its payer mix to see if it makes financial sense.

Another drawback is that insurers may not pay for surgical complications from the procedure or for maintenance required for LAGB (laparoscopic adjustable gastric banding).

"You need to keep complications low, otherwise [bariatric surgery] will cost you a fortune," says Cofield.

A study by the Agency for Healthcare Research and Quality found a 21.9% complication rate during the initial surgical stay, but the rate increased by 81% to 39.6% over the 6 months after discharge.

Cofield recommends that the finance and medical records departments work closely together to monitor factors such as payment rates.

Though payment could be better, Lund says, "We have decided bariatric surgery is the right procedure to offer our community. We know obese patients have multiple comorbid factors and are heavy users of other service lines that over time are more expensive than the surgery."

In the long term, she says, helping patients reduce their weight, possibly discontinue blood pressure and diabetic medications, reduce sleep apnea, and lead a more productive life "is the responsible thing to do."

Creative financing can help. Most hospitals arranged so patients can obtain low-cost loans with local banks, and most facilities require payment up front.

The Surgical Review Corporation (SRC), the accrediting body for the American Society for Bariatric Surgery (ASBS), is working with payers to establish ASBS as the standard for accreditation as a BCOE. Now that the program has accredited 180 centers, that comfort level is rising, says Gary Pratt, CEO for SRC.

Staffing and scheduling

Regular staff education and assessment of competencies, such as those for laparoscopic surgery, are essential. Sensitivity training is required to prepare staff to give emotional support to patients. Returning patients can help the staff gain insight into how they feel they were treated so adjustments can be made.

For the OR, Lund says her hospital hired one additional person to help position patients for surgery.

Regarding surgical scheduling, Berg says to ask whether the OR can provide scheduling that will make it cost efficient and productive for surgeons to want to work only at your center.

"We did this by giving our surgeons block time—2 rooms for each of our 2 surgeons on Monday and Tuesday and allowing them to do swing rooms for open cases," she says. The staff sets up for the second room while the surgeon is finishing in the first to minimize time between cases.

Scheduling cases early in the week avoids having the immediate postoperative period fall on the weekend when staffing is more limited.

Marketing the program

It's not enough to start a program and expect it to take off without help. Marketing is necessary. Ramsey says their physicians make presentations to the public, and marketing includes newspaper and radio ads. Lunds says sessions to educate the public about the procedure and patient participation in support groups after the procedure are key factors in the success of their program.

Because ambulatory surgery centers can now do some less complex bariatric procedures, Ramsey says it's important to maintain a strong marketing program and closely monitor patient volumes.

"It has to be a joint mission between hospital and physician to be successful," she says.

Choosing the type of accreditation

Once your program is up and running, it makes sense to become a BCOE, given the reimbursement considerations. The most common accreditation is conferred by ASBS, administered by SRC. SRC has more experience in accreditation than the other accrediting group, the American College of Surgeons (ACS).

Both programs require long-term data collection.

Pratt says data collection is an important part of SRC's program.

"If we just accredited centers, we would be fumbling the ball at the goal line," he says. "We're going to collect this data and return it to the people who can use it."

Future data will enable providers to stratify risks and may reduce or even eliminate SRC's requirement for programs to treat 125 patients per year. These requirements have drawn fire from rural centers, but Pratt notes they are based on data from the 2004 ASBS Consensus Conference.

Though SRC and ACS requirements are similar, Pratt says SRC does not believe in the levels approach advocated by ACS, which grants levels of accreditation based on volume. He says he thinks it's more important to concentrate "on the highest level of excellence." On the other hand, SRC includes industry stakeholders, which Pratt says ACS disagreed with including.

It typically takes 6 months or longer from initial submission to receive approval as a center of excellence.

Preparing for a site visit

A visit from a bariatric accrediting body is less disruptive than one from the Joint

Commission on Accreditation of Healthcare Organizations, but thorough preparation is important. Reviewers examine charts, visit areas of the hospital to ensure patients' needs are met, and ask questions of the staff.

OR managers recommend gathering all the information needed ahead of time. This includes copies of education materials, the medical director job description, credentialing paperwork for surgeons (including those who cover call), standardized orders, and clinical pathways, which should include pain and wound management and deep vein thrombosis prophylaxis. Put stickers on equipment to make the weight limits clear.

Last but not most important: Read the requirements carefully and be sure you meet them. And be committed to the patient, not the program.

The emotional factor

Patients undergoing bariatric surgery have serious emotional needs. They face the stigma of obesity and the erroneous perception that the surgery is "elective."

"This surgery is just as important as open heart surgery is for a cardiac patient," says Cofield. "Patients should not have to check their dignity at the door."

To help prepare patients for surgery, Darvell says United Hospital holds a presurgical education program. An advanced practice nurse coordinates the 4-hour session, where patients get to see the equipment, such as special postoperative beds, and hear presentations by the dietitian, anesthesia provider, exercise physiologist, and nurses.

BCOEs are required to offer support groups after surgery for patients. Medical Center East also offers an e-group—an electronic support group.

If you decide to pursue bariatric surgery and BCOE, the rewards will be immense, these nurse leaders say. The procedures dramatically change patients' lives, improving their quality and enjoyment of life. ❖

References

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- Buchwald H. Consensus conference statement: Bariatric surgery for morbid obesity: Health implications for patients, professionals, and third-party payers. *J Am Coll Surg*. 2005;200:593-604.
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Medicare coverage requirements

Patients:

- are morbidly obese (body mass index of 35 or greater)
 - have an obesity-related condition or disease
 - have not been successful with medical treatment for obesity.
- Coverage will be provided only if the surgery is performed by organizations certified by the American Society for Bariatric Surgery Surgical Review Corporation or the American College of Surgeons as a Level 1 Bariatric Surgery Program.
- Three types of procedures are covered:
- laparoscopic and open gastric bypass
 - laparoscopic adjustable gastric banding (LAGB)
 - open and laparoscopic biliopancreatic diversion and duodenal switch.

Options for accreditation

Two programs accredit bariatric centers of excellence:

American Society for Bariatric Surgery (ASBS) Surgical Review Corporation (SRC)

Designation: Bariatric Center of Excellence

Site reviewers: Bariatric nurses

Accredited centers: 180 inpatient

Sample accreditation requirements

Inpatient

- Centers must perform at least 125 bariatric surgeries per year, and each bariatric surgeon will perform at least 50 cases in the preceding 12-month period. Surgeons must be certified or board eligible and show evidence of bariatric surgical expertise in accord with guidelines of ASBS.
- Centers must track outcomes for at least 75% of patients for 5 years.

Application process: Centers must first apply for Provisional Status. Possible responses are approved, denied, monitoring status, and pending status. Monitoring status is used for centers with an insufficient volume of cases for the institution or surgeon. Applicants need to report volume in 6 months to be reevaluated. Pending status means more information has been requested for the evaluation process.

Approved centers have 2 years to apply for Full Approval. Center needs to show it can provide safe, effective bariatric surgery based on specified outcomes. The site review takes place at this stage.

Outpatient

Beginning November 2006 for LAGB only. Centers must perform at least 50 cases per year. Patients must be low risk: Younger than 60 years, BMI less than 55, weight less than 425 pounds, and an American Society of Anesthesiologists classification of less than IV, with no past history of DVT or PE.

Application fees

Surgeons: Provisional status: \$500. Full approval: \$1,000.

Hospitals: Provisional status: \$5,000.

Full approval: \$10,000.

American College of Surgeons

Designation: Bariatric Surgery Center

Site reviewers: Bariatric surgeons

Accredited centers: 17 inpatient, 1 outpatient

Levels of accreditation and sample requirements

Inpatient

Level 1a: Must perform a minimum of 125 weight-loss surgeries each year and have a minimum of 2 credentialed bariatric surgeons who perform a minimum of 50 primary weight-loss surgeries each year. Must participate in the ACS National Surgical Quality Improvement Program (NSQIP) for reporting outcomes data.

Level 1b: Same as Level 1a, except ACS NSQIP is not required; data is reported to ACS Bariatric Surgery Database for accreditation purposes only.

Level 2a: Must perform a minimum of 25 weight-loss surgeries each year and have one or more credentialed bariatric surgeons who perform at least 50 primary weight-loss surgeries each year. These centers aren't approved for high-risk patients (eg, men with BMI greater than or equal to 55, women with BMI greater than or equal to 60, cardiac or pulmonary comorbid conditions). Centers must participate in ACS NSQIP.

Level 2b: Same as Level 2a, except ACS NSQIP is not required; data is reported to ACS Bariatric Surgery Database for accreditation purposes only.

Outpatient

Provide LAGB surgeries. The credentialed bariatric surgeon must perform at least 50 primary procedures annually. Most requirements are the same as for Level 2b.

Application fee: \$10,000 triannually.