



For Immediate Release

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**BARIATRIC SURGERY HOSPITAL READMISSION AND INFECTION RATES DROP DRAMATICALLY
AFTER IMPLEMENTATION OF NEW PROTOCOLS**

**American Society for Metabolic and Bariatric Surgery and American College of Surgeons
To Implement New Quality Improvement Program**

ATLANTA, GA – NOV. 14, 2013 – The bariatric program at Stanford University saw hospital readmission rates drop by 75 percent and surgical-site infections decline by 60 percent after changes in patient education, discharge planning and pre-operative procedures, according to a new study* presented here at the 30th Annual Meeting for the American Society for Metabolic and Bariatric Surgery (ASMBS) during ObesityWeek 2013, the largest international event focused on the basic science, clinical application and prevention and treatment of obesity. The event is hosted by the ASMBS and The Obesity Society (TOS).

In 2008, the national benchmark for 30-day readmissions to the hospital after bariatric surgery was 5 percent; readmissions at the Stanford program were 8 percent. By 2012, the readmission rate at Stanford had fallen to 2 percent. Within the same period, the rate of surgical-site infections went from 2.5 percent to 1 percent, the national average.

“The study demonstrates the value of using validated national benchmarking data to identify areas for quality improvement in local bariatric programs,” said study author John Morton, MD, Director of Bariatric Surgery at Stanford Hospital & Clinics and President-Elect of the ASMBS. “The data prompted us to identify two areas that resulted in improved patient outcomes and a likely reduction in costs. If programs throughout the country focus on the areas where they diverge from the national standard, bariatric and metabolic surgery is likely to see even further improvements in safety and effectiveness.”

In January 2014, the ASMBS and American College of Surgeons (ACS) will launch the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), a program that establishes national standards for facilities and surgeons performing bariatric surgery. MBSAQIP calls for a certain level of surgeon experience in terms of the number of procedures performed annually and the submission of patient outcomes data to a national registry, among several other requirements. National benchmarks obtained from the registry will be used as the basis for establishing best practices and recommending quality improvement efforts. More than 700 bariatric programs are already enrolled in MBSAQIP.

In the Stanford study, hospital readmission and complication rate benchmark data was obtained from one of the precursor programs (ACS Bariatric Surgery Network) to MBSAQIP. Stanford then implemented targeted solutions against each of these benchmarks. For readmissions, patient education and discharge planning were emphasized on a daily basis, direct phone numbers for concerns were provided to patients, a registered nurse called each patient at home the first day after discharge, same day appointments were made available to address patient concerns and a clinical decision unit was utilized for 23-hour stays.

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Several process improvements were implemented to reduce surgical-site infections including the postponement of surgery and the referral to an endocrinologist if a patient's HgA1c level, a measure of blood sugar, was greater than 10. In addition, two grams of antibiotics, rather than one, were administered to the patient before the start of surgery.

"The highest quality care in bariatric surgery is occurring at accredited centers," added Dr. Morton, who is also Chief of Bariatric Surgery at Stanford University Medical Center. "These centers demonstrate their commitment to quality by constantly evaluating and re-evaluating what they do and how they do it to provide patients the best care possible. MBSAQIP will play a role in helping them do that by providing evidence-based data that they can act upon. The first national quality improvement project for MBSAQIP will be to decrease 30-day readmissions through the DROP (Decreasing Readmissions through Opportunities Provided) program."

In addition to Dr. Morton, study co-authors include Homero Rivas, MD, Tami Sell and Natalia Leva, MD, also from Stanford University Medical Center.

About Obesity and Metabolic and Bariatric Surgery

According to the Centers of Disease Control and Prevention (CDC), more than 78 million adults were obese in 2011–2012.¹ The ASMBS estimates about 24 million people have severe or morbid obesity. Individuals with a BMI greater than 30 have a 50 to 100 percent increased risk of premature death compared to healthy weight individuals as well as an increased risk of developing more than 40 obesity-related diseases and conditions including type 2 diabetes, heart disease and cancer.^{2,3}

Metabolic/bariatric surgery has been shown to be the most effective and long lasting treatment for morbid obesity and many related conditions and results in significant weight loss. The Agency for Healthcare Research and Quality (AHRQ) reported significant improvements in the safety of metabolic/bariatric surgery due in large part to improved laparoscopic techniques.⁴ The risk of death is about 0.1 percent⁵ and the overall likelihood of major complications is about 4 percent.⁶

About the ASMBS

The ASMBS is the largest organization for bariatric surgeons in the world. It is a non-profit organization that works to advance the art and science of bariatric surgery and is committed to educating medical professionals and the lay public about bariatric surgery as an option for the treatment of morbid obesity, as well as the associated risks and benefits. It encourages its members to investigate and discover new advances in bariatric surgery, while maintaining a steady exchange of experiences and ideas that may lead to improved surgical outcomes for morbidly obese patients. For more information, visit www.asmb.org.

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***A-126-AR: Utilizing National Clinical Data to Drive Quality Improvement -- John M. Morton, MD; Homero Rivas, MD; Tami Sell; Natalia Leva, MD; Presented November 14, 2013**

¹Prevalence of Obesity Among Adults: United States, 2011–2012. (2013). Center for Disease Control and Prevention. Access October 2013 from <http://www.cdc.gov/nchs/data/databriefs/db131.htm>

²Office of the Surgeon General – U.S. Department of Health and Human Services. (2004). Overweight and obesity: health consequences. Accessed October 2013 from http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences.html

³Kaplan, L. M. (2003). Body weight regulation and obesity. *Journal of Gastrointestinal Surgery*. 7(4) pp. 443-51. Doi:10.1016/S1091-255X(03)00047-7. Accessed October 2013.

⁴Encinosa, W. E., et al. (2009). Recent improvements in bariatric surgery outcomes. *Medical Care*. 47(5) pp. 531-535. Accessed October 2013 from <http://www.ncbi.nlm.nih.gov/pubmed/19318997>

⁵Agency for Healthcare Research and Quality (AHRQ). (2007). Statistical Brief #23. Bariatric Surgery Utilization and Outcomes in 1998 and 2004. Accessed October 2013 from <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb23.jsp>

⁶Flum, D. R., et al. (2009). Perioperative safety in the longitudinal assessment of bariatric surgery. *New England Journal of Medicine*. 361 pp.445-454. Accessed October 2013 from <http://content.nejm.org/cgi/content/full/361/5/445>