MBSAQIP®

METABOLIC AND BARIATRIC SURGERY
ACCREDITATION AND QUALITY IMPROVEMENT PROGRAM

Jordan Valley Medical Center

Accreditation Summary

Accreditation Award:	**Comprehensive Center**
Accreditation Through:	**07/24/2019 to 07/24/2022**
Name of Center:	**Jordan Valley Medical Center** **3580 West 9000 South** **West Jordan, UT 84088**
Facility ID Number:	**17944**
Name of Director/Leader:	**Catherine Beck, MD**
Date of Survey:	**07/24/2019**
Name of Surveyor:	**E. Patchen Dellinger, MD, FACS**
Name of Verified Surgeon(s):	**Catherine Beck, MD**

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9/17/2019

Catherine Beck, MD
3580 West 9000 South
West Jordan, UT 84088

Dear Catherine Beck, MD,

On behalf of the American College of Surgeons (ACS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), in partnership with the American Society for Metabolic and Bariatric Surgery (ASMBS), we would like to congratulate you and your team at **Jordan Valley Medical Center** on achieving a **Comprehensive Center** accreditation. A MBSAQIP accreditation for **Jordan Valley Medical Center** formally acknowledges your commitment to providing and supporting quality improvement and patient safety efforts for metabolic and bariatric surgery patients. As an accredited program you have demonstrated that your center meets the needs of your patients by providing multidisciplinary, high-quality, patient-centered care.

As a result of your accreditation, your bariatric program will be listed on our website at *www.facs.org/quality*. In order to demonstrate ongoing compliance with MBSAQIP Standards, your center will also be required to submit an annual report attesting to your center's compliance with all applicable standards (see Standard 7.3, "Ongoing Monitoring of Safety Culture" for details). A reminder will be sent to your center via e-mail prior to the anniversary month in which you were initially accredited with further details regarding annual report submission.

A press kit containing the MBSAQIP-accredited center seal and a press release template is available at *http://mbsaqip.org/mbsaqip/*. Carefully read the ACS Standards for Logo Use and accept the terms of the agreement at the bottom of the page to gain access to the press kit. Please encourage your marketing/public relations staff to post the MBSAQIP seal in a prominent location on your center or facility's website.

If you have any questions regarding this decision, please contact **Jaime Thomas** at **312-202-5210** or **jthomas@facs.org**.

We want to thank you for your support of the MBSAQIP and all that you do to meet the needs of the metabolic and bariatric surgery community. Your program is part of an elite group of MBSAQIP-accredited centers. Once again, congratulations on this achievement.

Sincerely,

David Provost, MD, FACS, FASMBS
MBSAQIP Standards and Verification Subcommittee Co-Chair

Wayne J. English, MD, FACS, FASMBS
MBSAQIP Standards and Verification Subcommittee Co-Chair

Attachments: Accreditation Summary, Performance Report, Chart Audit, and Verified Surgeon Letter(s)

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Facility ID#:	17944
Facility Name:	Jordan Valley Medical Center
Designation Seeking:	Comprehensive Center
Application Type:	Initial
Accreditation Status:	Fully Approved
Site Visit Date:	07/24/2019

Performance Report

Standard 1 Case Volume, Patient Selection, and Approved Procedures by Designation Level

1.1 Volume Criteria by Designation Level	Compliant
1.2 Patient and Procedure Selection – Low Acuity	N/A

Standard 2 Commitment to Quality Care

2.1 Metabolic and Bariatric Surgery (MBS) Committee	Compliant
2.2 Metabolic and Bariatric Surgery (MBS) Director	Compliant

2.3 Metabolic and Bariatric Surgery (MBS) Coordinator — Compliant

I have seen a thorough job description on Medical Center stationery signed by an HR representative.

2.4 Metabolic and Bariatric Surgery (MBS) Clinical Reviewer — Compliant

I have seen a thorough job description on Medical Center stationery signed by an HR representative.

2.5 Health Care Facility Accreditation — Compliant

2.6 Credentialing Guidelines for Metabolic and Bariatric Surgeons — Compliant

They have a detailed credentialing guideline including the necessity for maintaining certification and renewal schedule.

2.7 Metabolic and Bariatric Surgeon Verification — Compliant

Dr. Beck has 26 hours of CME credit during the past 3 years over all and has an additional 9 hours of bariatric CME from ASMBS in the past year.
Dr. Beck is a verified bariatric surgeon.

2.8 Qualified Metabolic and Bariatric Surgery Call Coverage — Compliant

2.9 Designated Area of Facility — Compliant

2.10 Designated Personnel — Compliant

Standard 3 Appropriate Equipment and Instruments

3.1 Facilities, Equipment, and Instruments — Compliant

Standard 4 Critical Care Support

4.1 Advanced Cardiovascular Life Support (ACLS)-Qualified Provider — Compliant

4.2 Ability to Stabilize Patients and Transfer — Compliant

They can handle essentially everything, but in the rare case that might occur they have a transfer agreement with the University of Utah.

4.3 Written Transfer Agreement — Compliant

4.4 Required Available Services — N/A

4.4-1 Anesthesia Services — Compliant

4.4-2 Critical Care Unit (CCU)/Intensive Care Unit (ICU) Services — Compliant

4.4-3 Comprehensive Endoscopy Services — Compliant

4.4-4 Comprehensive Diagnostic and Interventional Radiology Services — Compliant

4.4-5 Access to Additional Required Services — Compliant

Standard 5 Continuum of Care

5.1 Patient Education Pathways — Compliant

Very extensive, complete materials.

5.2 Perioperative Care Pathways — Compliant

5.3 30-Day and Long-Term Follow-Up — Compliant

5.4 Support Groups — Compliant

They have several support groups run by dietitians, physical therapists, and nurses. In their outpatient facility they have a large gym with extensive equipment and their bariatric physical therapist instructs patients on how to use the equipment. The hospital provides a weekly free access to this gym with the therapist present for all bariatric patients who have been operated there.

Standard 6 Data Collection

6.1 Data Entry of All Metabolic and Bariatric Procedures and Interventions — Compliant

6.2 Data Reports, Quality Metrics, and Quality Monitoring — Compliant

They have been compiling and reviewing locally produced documents about all of their patients until they can have access to SARs.

Standard 7 Continuous Quality Improvement Process

7.1 Institutional Collaborative — Compliant

7.2 Quality Improvement Process — Compliant

In addition to the length of stay related to O2 saturations that is uploaded in the application, I also reviewed a nice quality project aimed at reducing opioid use in their patients.

7.3 Ongoing Monitoring of Safety Culture — Compliant

Standard 8 Ambulatory Surgery Centers

8.1 Inpatient Admitting Privileges — N/A

8.2 Stapling Procedures in Ambulatory Surgery Centers — N/A

8.2-1 Risk Assessment Protocol — N/A

8.2-2 Additional Data Collection and Monitoring for Quality Improvement: Emergency Department Visits, Readmissions, and Transfers to Other Facilities — N/A

Standard 9 Adolescent Center Accreditation

9.1 Co-Surgeon Requirement for Children's Hospitals	N/A
9.2 Addition to Metabolic and Bariatric Surgery (MBS) Committee	N/A
9.3 Behavioral Specialist	N/A

Summary of Overall Comments

Strengths:

The program is well structured and organized.

This is a smaller hospital where everyone knows everyone else and with a clear hospital-wide commitment to excellent care.

Deficiencies & Recommendations for Improvement:

None found.

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SURVEYOR CHART AUDIT

Surveyor: E. Patchen Dellinger, MD

Site Visit Date: 24 July 2019

All MBSAQIP Site Surveyors must perform an in-depth chart review of at least 10 complication charts while surveying a center's Metabolic and Bariatric Surgery (MBS) program. The chart review serves as an early evaluation of the center's overall performance which will inform future discussions throughout the site visit and the exit interview.

Identify and provide within the Case Summary:

- Summary of the patient's preexisting medical conditions and risk factors for surgery
- Narrative of the patient's clinical course and progression of care
- Use of standardized order sets (pre, peri, and post-operative) between MBS procedures, MBS surgeons, and MBS personnel
- Issues with coordination of care for MBS patients (i.e. hand-off communication or other transition of care opportunities)
- Adequacy of clinical documentation
- Overall impressions regarding opportunities for improvement which can be identified for the MBS program
- Overall impressions regarding strengths of the MBS program which should be emphasized and encouraged
- **<u>Exclude</u> any Protected Health Information (PHI), including the following:**
  - **Specific dates (date of birth/operation/readmission/discharge)**
  - **Exact BMI or exact weight**
  - **Patient names or identifiers**

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SURVEYOR CHART AUDIT

1. **DO NOT** include any patient identifiers or Protected Health Information (PHI) in this document.
2. After the site visit, upload this form to the Surveyor Portal, Chart Audit tab within the center's application.

Case 1

Attending Surgeon: Eakin

Procedure: Small bowel obstruction w/ gastric bypass

Case Details:

Reason for Review: Reoperation

Body Mass Index: Less than 35

Patient Gender: Female

Patient Age: 40-49 Years

Case Summary (Exclude PHI):

46 yo woman with history of gastric bypass in past at outside hospital presented to the E.D. with abdominal pain, nausea & vomiting. CT suggested bowel obstruction. At laparotomy the patient had an internal hernia caused by adhesions which were lysed. The stomach was opened and decompresses and evacuated and a gastrostomy placed due to the extensive gastric distention. Postoperatively she was judged malnourished and had poor oral intake and received tube feedings. She developed pneumonia and was treated. She was discharged after 7 days with feeding gastrostomy and wound VAC. Two weeks after discharge she returned with complaint of drainage appearing in her VAC. She had a CT and was re-explored with drainage of an intra-abdominal abscess. She was discharged after 4 days to a long-term care facility which she had refused after the first admission. A month later she was improving with healing incisional wound. A month later her G-tube was removed.

Strengths or Opportunities for Improvement:

Prompt and effective management of complication from bariatric procedure done elsewhere.

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Case 2

Attending Surgeon: Beck

Procedure: Reversal of duodenal switch

Case Details:

Reason for Review: LOS >7 Days

Body Mass Index: Less than 35

Patient Gender: Male

Patient Age: 50-59 Years

Case Summary (Exclude PHI):

58 yo male with history of duodenal switch at outside and malnutrition on NG tube feeds and experiencing dizziness, blackouts falls, confusion, and memory loss was evaluated and started on TPN to improve nutritional status before operation. After improvement he went to the O.R. where he was found to have only 110 cm of common channel. This was revised to a 50 cm BPD, 70 cm Roux limb and 550 cm common channel. Postoperatively the patient had transient hypotension managed with fluid administration, renal failure, and development of ascites managed with paracentesis. He developed a DVT managed with heparin drip and then Eliquis. He developed C. difficile colitis which was successfully treated. After 2 weeks he was discharged to a rehab center. He was improving on clinic visit 5 weeks later. His kidney and liver functions were normal and his nutrition had improved.

Strengths or Opportunities for Improvement:

Complex case dealing with complications from a bariatric procedure done elsewhere. Managed well.

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Case 3

Attending Surgeon: Beck

Procedure: Lap Sleeve Gastrectomy

Case Details:

Reason for Review: Readmission

Body Mass Index: 46-50

Patient Gender: Female

Patient Age: 30-39 Years

Case Summary (Exclude PHI):

46 yo woman with morbid obesity, hypertension, sleep apnea, osteoarthritis, and PCOS underwent full, thorough preoperative testing and counseling. She proceeded to a standard lap sleeve starting 6 cm from pylorus over a 42 French bougie with subsequent EGD and negative leak test. A flat drain was left. She was discharged 3 days later without problems. She was seen in clinic 2 weeks postop with some nausea and pain with eating. 10 days later she presented to the ED with nausea and vomiting. She was diagnosed with a UTI, was hydrated, given antibiotics, and sent home. Five days later because of similar symptoms she was admitted overnight for hydration. A month later she was still having frequent symptoms. On evaluation she was found to have cholelithiasis which had not been present before her sleeve. She was scheduled for laparoscopic cholecystectomy and improved significantly.

Strengths or Opportunities for Improvement:

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Case 4

Attending Surgeon: Eakin

Procedure: Lap band removal and lap sleeve gastrectomy

Case Details:

Reason for Review: Readmission

Body Mass Index: 41-45

Patient Gender: Female

Patient Age: 30-39 Years

Case Summary (Exclude PHI):

34 yo woman with history of hip replacement for dysplasia and morbid obesity with sleep apnea and with history of 2 ineffective lap band placements. She had a full preoperative workup and then went to the O.R. for lap removal of prior band and then lap sleeve starting 5 cm from pylorus over a 42 French bougie. EGD showed no bleeding or leak. A flat drain was placed. She was discharged on POD #4. Five days post discharge she had increased abdominal pain and came to clinic. She was admitted for evaluation. CT was negative and drain was removed. She had some erythema around the drain site, < 5 cm. She was discharged the next day. Three weeks later she was seen in clinic with complaint of nausea relieved by Zofran.

Strengths or Opportunities for Improvement:

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Case 5

Attending Surgeon: Beck

Procedure: Lap Sleeve

Case Details:

Reason for Review: Readmission

Body Mass Index: 35-40

Patient Gender: Female

Patient Age: 50-59 Years

Case Summary (Exclude PHI):

50 year old woman with prior history of lap band and subsequent band removal. She had morbid obesity, diabetes, GERD, hypertension, low back pain, osteoarthritis, gout, and sleep apnea. She had the complete preoperative workup and then proceeded to lap sleeve starting 6 cm from pylorus over a 42 French bougie. EGD showed no stricture and no leak. She also had repair of a port site hernia from her prior lap band procedures and a flat drain was placed. She was discharged on the second postoperative day. A week postop she presented with left sided abdominal pain and vomiting. A CT showed dilated SB loops with transition in the lower abdomen. She was admitted and treated conservatively and resolved and was discharged 6 days later and her drain removed. She was found to have a remote history of Crohn's disease that had not been treated or followed in recent years. Ten days later she was doing well.

Strengths or Opportunities for Improvement:

Careful, conservative management of partial SBO.

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Case 6

Attending Surgeon: Beck

Procedure: Lap sleeve

Case Details:

Reason for Review: Readmission

Body Mass Index: 46-50

Patient Gender: Female

Patient Age: 40-49 Years

Case Summary (Exclude PHI):

40 yo woman with morbid obesity, diabetes, asthma, hypertension, low back pain, osteoarthritis, gout, and sleep apnea and a history of 3 previous hernia repairs. She had the full standard workup and then proceeded to the O.R. At laparoscopy, the patient was found to have extensive, dense adhesions and the procedure was converted to open. Some small bowel was densely adherent ("grown into") to the mesh and was resected. After this had been completed, trocars were placed and the abdomen closed and the procedure proceeded laparoscopically for the sleeve resection. A standard sleeve was done over a 42 French bougie and EGD showed no stricture or leak. A flat drain was left. UGI on POD #1 showed no leak. She did well and was discharged on POD #4. Seven days after discharge she returned after a popping sensation followed by abdominal pain and some vomiting. CT showed upper abdominal abscesses. UGI showed a small gastric leak. IR drain was placed and she was admitted for 2 weeks with IV support and antibiotics. 6 weeks later she was slowly improving but still with some nausea and epigastric pain when eating.

Strengths or Opportunities for Improvement:

Appropriate, safe management of difficult operative case.

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Case 7

Attending Surgeon: Beck

Procedure: Lap sleeve

Case Details:

Reason for Review: Readmission

Body Mass Index: 46-50

Patient Gender: Female

Patient Age: 30-39 Years

Case Summary (Exclude PHI):

35 yo woman with morbid obesity and hypertension. She had the full, standard workup and the proceeded to lap sleeve gastrectomy starting 6 cm from pylorus over 42 French bougie. EGD showed no stricture or leak. She was discharged on POD #2. She was seen in clinic 2 weeks postop and reported difficulty taking liquids. Drain was removed. A week later she presented to the E.D. with chest pressure and tingling. CT showed possible small, contained sleeve leak, later reinterpreted as small amount of air following drain removal. She was admitted for observation and IV fluids and discharged 2 days later. She was seen 3 months later in clinic doing well with significant weight loss.

Strengths or Opportunities for Improvement:

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Case 8

Attending Surgeon: Beck

Procedure: Lap sleeve

Case Details:

Reason for Review: Readmission

Body Mass Index: 41-45

Patient Gender: Female

Patient Age: 50-59 Years

Case Summary (Exclude PHI):

50 yo woman with morbid obesity, sleep apnea, prediabetes, and hypertension. She had the full standard workup and proceeded to the O.R. for a lap sleeve beginning 6 cm from pylorus over a 42 French bougie followed by an EGD showing no stricture or leak. She was discharged on the second postoperative day. She returned a week later complaining of abdominal pain and constipation. CT showed an abdominal fluid collection and she was admitted. Review of films and history suggested constipation and patient had not been taking her stool softener. She felt better after 2 days and was discharged with laxatives. She was seen 4 days later and reported having had bowel movements and feeling better. Two weeks later she was still well. Three months postop she was doing well and having significant weight loss.

Strengths or Opportunities for Improvement:

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Case 9

Attending Surgeon: Beck

Procedure: Lap sleeve

Case Details:

Reason for Review: Readmission

Body Mass Index: 51-55

Patient Gender: Female

Patient Age: 50-59 Years

Case Summary (Exclude PHI):

55 yo woman with morbid obesity, sleep apnea, diabetes, history of Nissen fundoplication, and chronic pain syndrome. She had the full standard workup and proceeded to the O.R. She had takedown of the Nissen followed by sleeve gastrectomy starting 6 cm from pylorus over a 42 French bougie. EGD showed no stricture or leak. She was discharged on the second postoperative day. Three weeks postop she was seen in clinic doing well. Three weeks later she complained of pain and not being able to advance her diet. She had an UGI which was normal and a month later she reported slow improvement. Four days later she came to E. D. with increased difficulty, signs of dehydration and fever. CT showed possible abscess. IR placed a drain and shortly afterward she developed septic shock. This was treated and she recovered and was discharged after a week in the hospital with better oral tolerance. Two weeks later she was doing well in clinic and had her drain removed.

Strengths or Opportunities for Improvement:

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Case 10

Attending Surgeon: Beck

Procedure: Lap sleeve

Case Details:

Reason for Review: Readmission

Body Mass Index: 35-40

Patient Gender: Female

Patient Age: 50-59 Years

Case Summary (Exclude PHI):

52 yo woman with morbid obesity, hypertension, sleep apnea, and GERD had full preoperative workup and proceeded to lap sleeve starting 6 cm from pylorus over 42 French bougie. EGD showed no stricture or leak. She was discharged on the second postoperative day. Two and half weeks later she presented to the ED with abdominal pain, chest pressure, and dyspnea. CT showed a fluid collection vs. phlegmon near the stomach and diaphragm that was not accessible for IR drainage. She was admitted on antibiotics for observation. The patient felt much better and was discharged on antibiotics 2 days later. Nine days later she was seen in the office feeling well.

Strengths or Opportunities for Improvement:

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ACCREDITATION AND QUALITY IMPROVEMENT PROGRAM

9/17/2019

Catherine Beck, MD
3580 West 9000 South
West Jordan, UT 84088

Dear Catherine Beck, MD,

The Standards and Verification Subcommittee for the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), in partnership with the American Society for Metabolic and Bariatric Surgery (ASMBS) would like to officially recognize you as a MBSAQIP Verified Surgeon for **Jordan Valley Medical Center.**

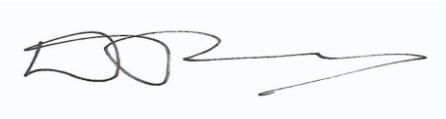
This letter confirms that ***Catherine Beck, MD*** has demonstrated compliance with all of the criteria outlined in Standard 2.7 of *Resources for Optimal Care of the Metabolic and Bariatric Surgery Patient 2016.*

Your verification period is concurrent with **Jordan Valley Medical Center's** triennial accreditation cycle which is effective from ***07/24/2019*** through ***07/24/2022.***

Should you leave **Jordan Valley Medical Center**, you are required to report the status change to the MBSAQIP by contacting us at mbsaqip@facs.org.

Congratulations on this recognition and thank you for your commitment to high quality metabolic and bariatric surgical care.

Sincerely,



David Provost, MD, FACS, FASMBS
MBSAQIP Standards and Verification Subcommittee Co-Chair

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MBSAQIP Standards and Verification Subcommittee Co-Chair