

# Bariatric Continuity Partners

## A new model for care

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# Speaker Disclosures

None in the past 12 months  
relevant to this presentation

# Think Tank Discussion

# ASMBS Metabolic and Bariatric Surgery Numbers Estimation for 2017

	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>
Sleeve	28,124	57,090	75,359	99,781	105,448	125,318	<b>135,401</b>
RYGB	57,986	64,875	61,218	51,724	45,276	40,316	<b>40,574</b>
Band	55,932	34,946	25,060	18,335	11,172	7,310	<b>6,318</b>
BPD/DS	1,422	1,730	1,790	772	1,176	1,236	<b>1,588</b>
Revision	9,480	10,380	10,740	22,195	26,656	30,077	<b>32,238</b>
Other	5,056	3,979	4,833	193	6,272	5,665	<b>5,606</b>
Balloons					700	5,744	<b>6,280</b>
Total	158,000	173,000	179,000	193,000	196,700	215,666	<b>228,005</b>

5 year total = 1,012,371 patients

A Proposal: Why We Need a New Aftercare Plan  
BT Online Editor | September 22, 2011  
by Eric J. DeMaria, MD

- Biggest problem in bariatric surgery care today remains the issue of **follow up**
  - promoting successful long-term behavior modification.
  - surveillance for complications
  - prevent the various nutritional issues that can arise long term.
  - collect long-term data, the lack of which has hampered acceptance by payors and medical doctors alike.

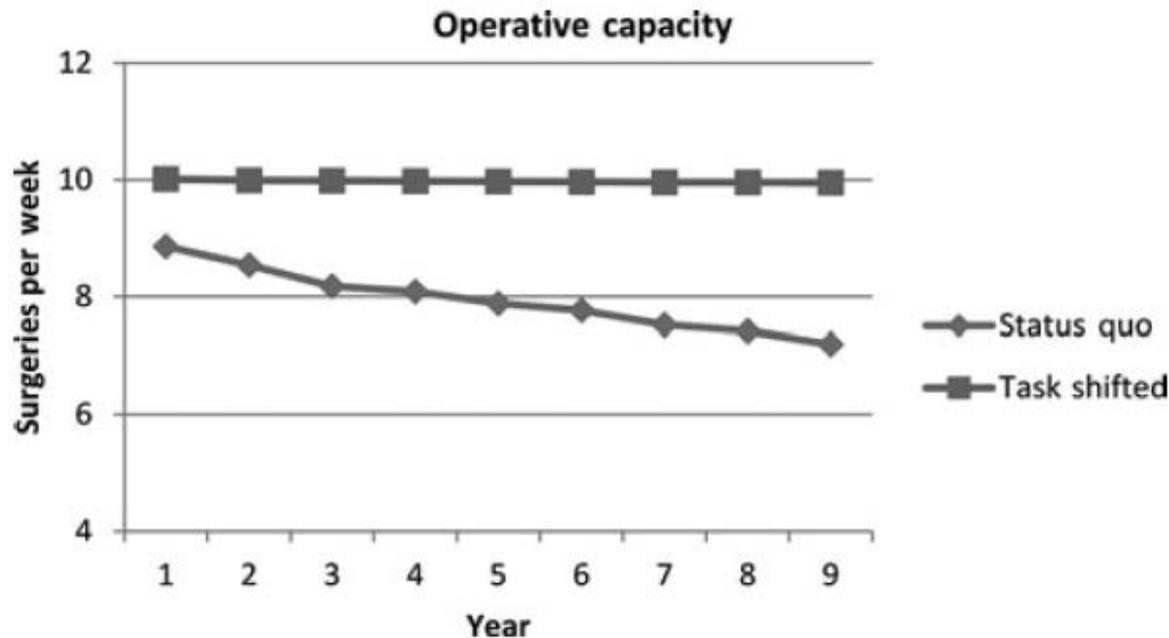
- Over 5 yrs in the US, one could estimate that we “create” one million postoperative patients, each requires at least one annual follow-up exam = one million follow-up visits, assuming that each patient follows current guidelines.
- In order to perform 200,000 operations with 2 preoperative visits per procedure. That is 400,000 more visits over the course of one year.
- Postop patients are not seen once, but rather four times in year 1. This increases our burden of postoperative visits from one million to 1.6 million encounters, as the most recent year visits increase from 200,000 to 800,000.
- US bariatric surgeons would be responsible for 2 million office visits, which is about 10 times the number of annual surgeries. And this model does not include the probability that some patients will require more than the minimum number of encounters.

- 2,000 bariatric surgeons
  - 1,000 visits each year (21 visits per week) in order to keep up with our patients operated during the last five years.
- If we evaluate a 10-year period of high-volume bariatric surgery
  - 2,000 bariatric surgeons need to provide 3 million patient encounters per year (15 times the number of surgeries), or 31 visits per week just to keep up with the aftercare needs of patients.
- Bariatric surgery has been around for decades, so these numbers are very conservative in estimating the amount of care bariatric surgeons really would need to provide to patients long term if they followed our guidelines for annual follow-up care.

## Increasing Access to Specialty Surgical Care

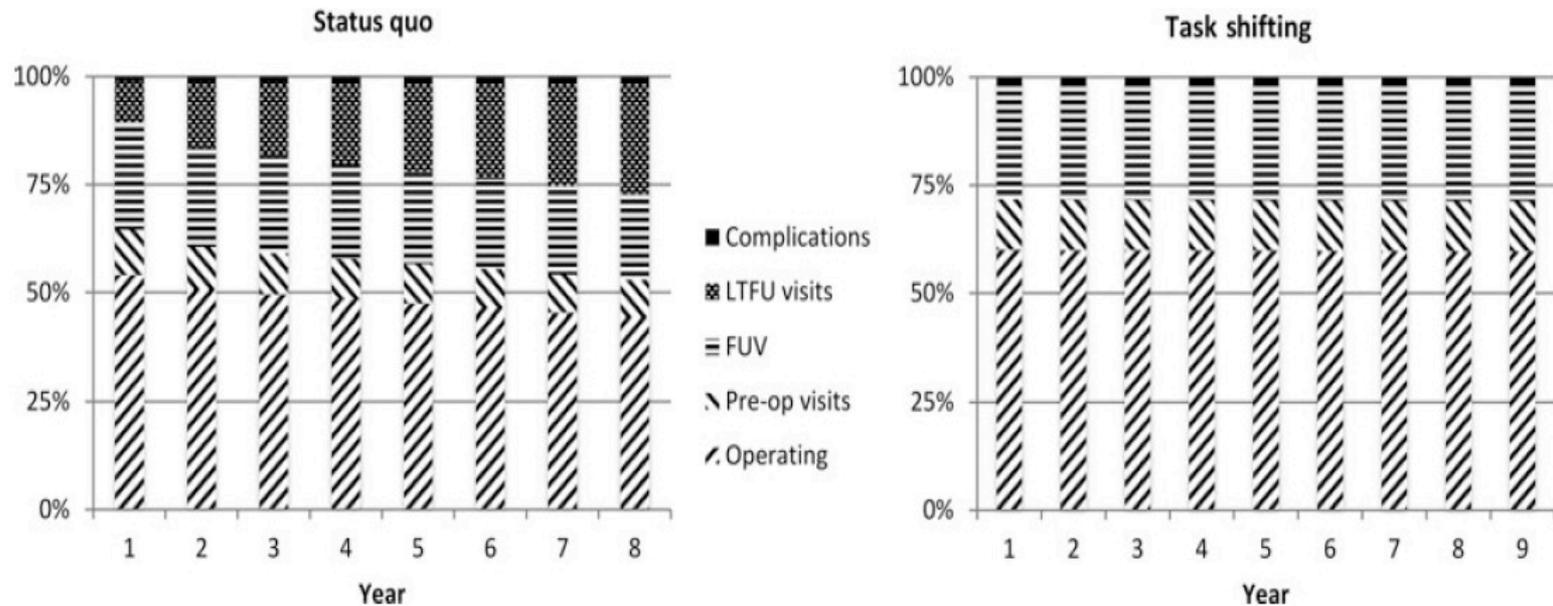
### *Application of a New Resource Allocation Model to Bariatric Surgery*

*Eric J. Leroux, MD, MBA,\*† John M. Morton, MD, MPH, MHA,‡ and Homero Rivas, MD, MBA‡*



**FIGURE 1.** Comparison of operative capacity between surgeon-centered postoperative care (status quo) and task-shifting routine LTFU visits to ancillary health care professionals.

# Task shifting LTFU to other providers



**FIGURE 2.** Comparison of a surgeon's clinical duties and associated allocation of his or her time between the status quo scenario and the task-shifted model. FUV indicates follow-up visits that are within 90 days of surgery; Pre-op, preoperative.

- Breakpoint analysis shows that at a fixed rate of 8 surgical procedures per week, a bariatric surgeon will reach capacity after 2 to 4 years, depending on postoperative visit attendance. This necessitates a reduction in surgical volume unless other growth-sustaining practices are introduced.
- Steady-state analysis describes a logarithmic increase in time allocated to LTFU visits such that the hourly weekly allocation to these uncomplicated visits in years 2, 4, 6, and 8 is 7.8, 9.6, 11.3, and 13.0, respectively.

- Thus, the difference in surgical capacity between the status quo and the task-shifted model increases with time, in accordance with the logarithmically increasing OC of a surgeon seeing patients for LTFU visits such that after 1 year, task shifting results in a 12% increase in operative capacity, 20% at 2 years, 26% at 3 years, and reaches 38% after 9 years.
- Consequently, the steady state shows that in the status quo model, 43% of a surgeon's clinical time is spent operating and 27% is allocated to seeing patients at LTFU visits. Task shifting the LTFU visits to other health care professionals generates a new steady state in which 60% of a surgeon's time is spent operating, representing an average increase in operative capacity of 34%.

Status quo

- Is it any wonder that surgeons might be considered ambivalent about patients not coming back for follow-up care?
- Could we realistically fit this many patients into our clinic schedules?
- We probably would not be able to be surgeons with this exponentially increasing burden of providing long-term care if patients actually came back as they are supposed to do.

- the bariatric surgeon workforce cannot support the follow-up care of all bariatric surgery patients long term. It is an impossible burden to place on this specialty and we must seek new answers to this problem.
- Although most surgeons are genuinely concerned about their patients, we are fighting a losing battle in this numbers game.
- our failure is that we have not been able to figure out a better system of care to make certain our patients' needs are met long term.

This demand for longterm aftercare will continue to outpace our available resources as bariatric surgeons.

...it is past time to solve this problem. Our patients' long-term success and safety depend on it.

Bariatric  
Continuity  
Partner:

A new model of care

- ...a reasonable answer lies in equipping our primary care providers with the education and skills they need to provide high-quality longterm care to our postop patients
- In addition, public identification of providers who have acquired this knowledge and skill will allow the public to seek out their care.



# Why PCP's as Bariatric Continuity Providers?

Other options

- Medical bariatricians
- Gastroenterologists
- Surgeons' Advanced Care Providers (PA's NP's)

PCP's:

Most patients have a pcp

Huge numbers of providers

wide geographic distribution across USA

Other reasons that patients do not  
receive follow up from their  
MBS programs

# Americans are the most mobile people

Between 2011 and 2012, Gallup uniformly asked 236,865 adults in 139 countries whether they had moved from another city or area within their country in the past five years. These 139 countries represent more than 97% of the world's adult population, enabling a reliable global estimate.

*Internal Migrants Worldwide, by Education and Age*

	Total Internal Migrants	Primary or less	Secondary	College	Ages 15 to 29	Ages 30 to 49	Ages 50+
World	8%	5%	10%	13%	10%	8%	5%
Northern America	24%	*	23%	24%	33%	29%	14%
Australia/ New Zealand	18%	*	18%	21%	28%	20%	9%
Sub-Saharan Africa	12%	10%	15%	20%	14%	12%	7%
Middle East	12%	11%	13%	14%	13%	13%	9%
Latin America	10%	9%	11%	13%	12%	11%	6%
Developed Asia	10%	7%	10%	14%	12%	16%	6%
European Union	9%	5%	9%	13%	16%	11%	4%
North Africa	8%	7%	9%	12%	8%	9%	5%
Europe Other	6%	4%	6%	13%	8%	6%	3%
CIS	6%	5%	7%	7%	8%	6%	5%
Developing Asia	5%	4%	6%	9%	6%	5%	3%

Based on surveys in 139 countries between 2011 and 2012

\*Sample sizes too small to report.

GALLUP

# People with employer sponsored insurance who changed health plans in previous 12 months

**Table 1**  
**Nonelderly People with Employer-Sponsored Insurance Who Changed Health Plans in Previous 12 Months, 2003 and 2010**

	2003	2010
Any Plan Change	17.2%	12.8%*
Plan Change Because of Job Change	5.1	5.1
Plan Change for Other Reason <sup>1</sup>	12.0	7.5*
Employer Changed Plan Offerings	65.5	62.7
Employee Changed Plan to Reduce Cost	20.3	23.0
Employee Changed Plan for Better Quality	11.7	10.9
Other Reason	13.1	15.8

<sup>1</sup> Respondents could select more than one reason.

\* Change from 2003 is statistically significant at  $p < .05$ .

Sources: HSC 2003 Community Tracking Household Survey and 2010 Health Tracking Household Survey

18.3% in 2014

17.3% in 2015

**Center for Studying Health System Change (HSC).**

A Proposal: Designating Qualified Bariatric Aftercare Programs and Providers to Aid in Long-term Bariatric Patient Followup

BT Online Editor | October 14, 2011

by Eric J. DeMaria, MD

- “Why isn’t there a bariatric primary care provider I can see?”
- I have sat in on focus groups with bariatric surgery patients discussing how they feel about their long-term postsurgical care. Inevitably, as they delve into the issues of how to obtain long-term care after bariatric surgery, one of the participants, often in frustration, will ask this same question.

- patients could benefit greatly from a partnership between medical and bariatric specialties that strives to provide safe, long-term care to our patients.
- generally, that care is to provide surveillance for issues that might arise rather than providing further interventions.
- Why do we return people to better overall health, yet believe that only bariatric surgeons are capable of providing the basics of long-term care for this much healthier population? The term wellness care more aptly describes the care that most patients who have undergone bariatric surgery need long term.

# PCP's as Bariatric Continuity Partners

- Most patients are motivated to find a PCP no matter where they live / move to
- A patient's PCP accepts their insurance
  - Co-pays are lower than specialist co-pays
- A patient's PCP is usually nearby and sees the patient on a regular basis
- A patient's PCP typically receives the first patient call when they are ill
- Strengthens the partnership between PCP's and bariatric/metabolic surgeons

# BCP program

- Develop in partnership with PCP organizations including ACP's
- Pre and Post op care algorithms
- Enhance **Essentials of Bariatric Surgery app**
- Pros and Cons of offering a certificate
- Possibility of listing providers for patients to identify qualified individuals

# Obstacles

- Unclear if PCP's are interested in enhanced training / education / participation in bariatric surgery patient care

# Summary

- Follow-up remains the most serious problem in bariatric surgery
- Aftercare by bariatric/metabolic surgeons is a flawed concept for many reasons
- Development of a non-surgical specialist to provide bariatric surgery longterm care has many potential advantages for patients and the surgical specialty
- Proposal to develop a program to develop Primary Care Providers as BCP's