

Healthgrades Bariatric Surgery Report 2014

The most recent data on obesity in the United States show that more than one-third of adults, more than 78 million U.S. adults, are obese.¹ The number of severely obese adults is forecasted to double in the next 20 years.² In June 2013, the American Medical Association designated obesity as a disease. In addition, the long-term health benefits of weight loss have been well documented. All of these indicators lead to a likely increase in demand for treatment options for obesity, including bariatric surgery.

As demand for bariatric surgery grows, hospital executives may consider adding or expanding their services in this area. Strategic decisions must be made with an eye on three goals:

- Improving clinical outcomes
- Maximizing reimbursement and profitability
- Increasing preference for your services

One approach aimed at meeting those goals may be achieving Center of Excellence (COE) designation. Recent studies and changes in reimbursement criteria by the Centers for Medicare and Medicaid Services (CMS) have put into question the measureable benefits of a COE designation. Is there a benefit to the patient and the organization to pursue COE designation?

Healthgrades focused on understanding what the data shows in specific terms: *Do hospitals that have COE designation have lower complication rates than those that do not?*

Healthgrades analysis suggests that a statistically higher percentage of hospitals with COE designation are rated 5-stars for bariatric surgery (21% of those with designation relative to 8% of those without). However, COE designation alone is not enough.

As a group, the risk-adjusted complication rate for COE designated facilities is not statistically different from the non-designated facilities (5.18% vs. 5.37%). This suggests that COE designation alone does not equate to high performance in terms of in-hospital complications. In addition to top performers, over 27% COE designated facilities performed statistically worse than expected according to the Healthgrades methodology.

The data consistently shows however, there is variation in hospital performance for bariatric surgery. Healthgrades identified 70 hospitals whose complication rates were significantly lower than predicted given their patients' health conditions. In addition, Healthgrades recognized a subset of these hospitals as the top 10%—the best of the 5-star performers—and named them Healthgrades Bariatric Surgery Excellence Award™ recipients for 2014.

CHOOSING THE RIGHT PROVIDER FOR BARIATRIC SURGERY IS CRITICAL



Healthgrades Bariatric Surgery Report

Patients having bariatric surgery at hospitals with 5-star performance in bariatric surgery had:

 **70%**
lower risk of experiencing
in-hospital complications

than patients at hospitals with 1-star.

*Statistics based on analysis for three years for all-payer data (2010-2012) from 17 states that make their all-payer data publicly available for all three years.



Healthgrades Bariatric Surgery Report

From 2010 through 2012, if all hospitals had performed at the same level as Bariatric Surgery Excellence Award™ hospitals:

4,349
patients could have potentially
avoided a major in-hospital
complication.

*Statistics based on analysis for three years for all-payer data (2010-2012) from 17 states that make their all-payer data publicly available for all three years.

Center of Excellence Accreditation

To pursue COE or not to pursue COE

Bariatric surgery is one clinical competency that has been privy to this Shakespearean-inspired question. Pursuing a COE requires a focus and investment from hospital executives and service line leadership. Achieving COE status requires structural and programmatic investment, whether the accrediting entity is private (e.g., Blue Cross Blue Shield) or public (e.g., Centers for Medicare and Medicaid Services).

The COE requirements for bariatric surgery focus less on performance for risk-adjusted outcomes and more on structural and programmatic elements, such as number of cases performed annually, non-operative weight loss options, and program infrastructure.

The Centers for Medicare and Medicaid Services (CMS) required hospitals to be accredited with a Bariatric Surgery COE designation to receive reimbursement for bariatric surgery from 2006 through September 24, 2013. CMS made a change to this requirement soon after a study conducted by Dimick et al. and sponsored by the Agency for Healthcare Research & Quality (AHRQ), focused on Medicare patients from 2004 to 2009 who underwent bariatric surgery.³

The study assessed clinical outcomes including complications, serious complications, and reoperation rates. Study results revealed that bariatric surgery outcomes improved during the study period in both Medicare and non-Medicare patients. However, after accounting for patient factors, changes in procedure types, and preexisting time trends toward improved outcomes, there were no statistically significant differences in the rates of complications and reoperation before versus after the CMS policy of restricting coverage to COEs.

The American Society for Metabolic & Bariatric Surgery (ASMBS) and the American College of Surgeons (ACS)—the two societies hosting accreditation programs—combined their respective national bariatric surgery accreditation programs into a single unified program. The result is one national accreditation standard for bariatric surgery centers, the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

See *Table 1* for the differences in the programs before and after the merger.

Complication Rates by COE Designation

Healthgrades analyzed the performance of COE versus non-COE hospitals with regard to bariatric surgery care and the outcomes as measured in terms of complication rates. Our findings support the AHRQ-sponsored Dimick study regarding COE status and quality performance.

Although Healthgrades analysis found that most COE hospitals evaluated for the 2010-2012 time period had three times the volume (532 cases) compared to non-COE hospitals (131 cases), results showed that, as a group, COE hospitals showed no statistically significant difference in complication frequency, severity, or length of stay compared with non-COE hospitals.

METABOLIC AND BARIATRIC SURGERY ACCREDITATIONS AND QUALITY IMPROVEMENT PROGRAM (MBSAQIP) BEFORE AND AFTER

Table 1. MBSAQIP Before and After

| Type of Requirement | Before | After |
|-------------------------------|---|---|
| Accrediting Body | Two separate bodies: ASMBS and ACS | One unified body called MBSAQIP |
| Volume Requirement | ASMBS: 125 cases/year ACS: Tiered structure 125 cases/year for level 1 25 cases/year for level 2 | No volume requirement. Must meet minimum outcome measure score that is to be decided. |
| Data | Entered into Bariatric Outcomes Longitudinal Database (BOLD™) | BOLD™ suspended due to inaccuracies. MBSAQIP has a new system and process in place. |
| Staffing | Mandatory program coordinator position | Mandatory program coordinator and data collector/clinical reviewer. |
| Surgeon Certification | Bariatric surgeons with at least 50 cases/year for surgeon level COE designation | No COE designation for physicians; however, bariatric surgeon must be credentialed according to local guidelines. |
| Regional Collaborative | Optional | Required including attendance at twice-yearly meeting. |

Non-COE facilities had a risk-adjusted inpatient complication rate of 5.37% and the COE facilities had a 5.18% rate. In testing specific complication outcomes, there were no statistically significant differences for COE versus non-COE programs, and risk-adjusted length of stay for the COE facilities was not statistically significantly different (COE: 2.29 days and non-COE: 2.26 days).

While COE status may be related to structural, programmatic, or process measures, as it was defined from 2010 through 2012, there is little evidence to suggest that COE designation directly relates to patient outcomes in terms of in-hospital complications or length of stay.

Future Outlook for Bariatric Surgery Accreditation

The current and future impacts of the recent changes to accreditation include the following:

- 1 Benchmarked outcomes are a growing driver to measure efficacy of a clinical program or earn a designation.
- 2 The focus on outcomes is driving continued interest in collaboration. This is evident by the merger of the ASMBS and ACS to form ASMBSQIP, and the new mandate for MBSAQIP centers to join state- or regional-based collaboratives.
- 3 The focus on cost-effectiveness is driving a re-emphasis on non-operative weight loss options and the importance of behavior change post-surgery. A recent AMA resolution emphasizes that bariatric programs should provide a comprehensive offering that includes behavioral counseling so that outcomes are sustained and patients are well supported in their efforts for lifestyle changes.
- 4 Several questions remain to be answered: What are the outcomes that will be most aligned with bariatric quality moving forward? What is the role of the societies in determining measures? Who will administer the measurement? What is the appropriate balance between access to care and quality assurance?

Other Key Findings

Procedure Type Does Not Affect Risk-Adjusted Complication Rates

From 2010 through 2012, the percent of bariatric surgeries performed laparoscopically far exceeded open surgical procedures. Over 93% of all bariatric procedures were laparoscopic and 5.5% were open (Table 2). While the actual-to-predicted complication ratio was nearly equal by procedure type, the actual complication rate for open procedures was over twice the average of all laparoscopic procedure types.

HOW CONSUMERS ARE PAYING FOR SERVICES

Healthgrades found that from 2010 through 2012, patients with commercial insurance represented the majority undergoing bariatric procedures. Commercial insurance accounted for 68.0% of the patients undergoing a procedure, followed by government insurance at 26.7%, and other and self-pay at 5.3%.

Table 5: Bariatric Surgery Volume by Payer

| Payer | Total Cases 2010-2012 | % of Total Cases 2010-2012 |
|-----------------------------|-----------------------|----------------------------|
| Commercial Insurance | | 68.0% |
| Blue Cross | 30,600 | 15.31% |
| Blue Cross HMO | 10,851 | 5.43% |
| Commercial/Self-Insured | 30,079 | 15.05% |
| HMO/PPO | 64,426 | 32.22% |
| Government Programs | | 26.7% |
| TRICARE | 3,111 | 1.56% |
| Medicaid | 21,310 | 10.66% |
| Medicare | 26,572 | 13.29% |
| VA/Government | 2,295 | 1.15% |
| Other | | 5.3% |
| Self-pay | 9,437 | 4.72% |
| Unknown/Other | 1124 | 0.56% |
| Worker's Compensation | 121 | 0.06% |
| All | 199,926 | 100% |

17 STATES EVALUATED FOR BARIATRIC SURGERY

For bariatric surgery, Healthgrades evaluated hospitals from 17 states representing 45% of the U.S. population, where hospital patient outcomes data are publicly available (all-payer claims data from 2010 through 2012):

- Arizona
- Colorado
- Florida
- Iowa
- Maryland
- Massachusetts
- Nevada
- New Jersey
- New York
- Oregon
- Pennsylvania
- Rhode Island
- Texas
- Utah
- Virginia
- Washington
- Wisconsin

Our analysis also included a data from California (2010 through 2011) and Illinois (2011). Since these states did not have three years of data, we could not evaluate hospitals in these states.

Table 2. Frequency of Bariatric Surgery Procedure Types and In-Hospital Complications

| | In-Hospital Complication Rate | Actual-to-Predicted Complication Ratio | Total Cases 2010-2012 | Percent of Cases 2010-2012 |
|--|-------------------------------|--|-----------------------|----------------------------|
| Average and Total All Bariatric Procedures* | 4.83% | 1.00 | 199,926 | |
| Procedure Type | | | | |
| Laparoscopic Banding | 2.49% | 0.98 | 29,158 | 14.58% |
| Laparoscopic Sleeve | 4.25% | 1.00 | 22,624 | 11.32% |
| Other Laparoscopic | 5.00% | 1.00 | 135,690 | 67.87% |
| Open | 10.46% | 1.01 | 10,949 | 5.48% |

*1,505 procedures (0.75%) were documented using a procedure which can be done open or laparoscopically. These procedures were not included in the table above.

Respiratory Complications Are the Most Frequently Occurring Complications

The most frequently occurring complications among patients undergoing bariatric surgery were Hemorrhage (excessive or uncontrolled bleeding). Acute Renal Failure and Cardiac Complications (fibrillation or heart attack), were also among the **most frequent in-hospital complications**. In-hospital mortality (death) was rare (0.05%) with 5.1 deaths for every 10,000 cases (Table 3).

Table 3. In-Hospital Complications Associated With Bariatric Surgery

| In-Hospital Complication | Rate |
|---|-------|
| Hemorrhage Complicating a Procedure | 0.59% |
| Acute Renal Failure | 0.53% |
| Cardiac Complications, not elsewhere classified | 0.42% |
| Other Respiratory Complications | 0.38% |
| Accidental Puncture or Laceration | 0.37% |
| Mortality | 0.05% |

Hospitals With Highest Volume Had Lowest Complication Rates

The number (volume) of bariatric procedures a particular hospital performs was an important factor associated with the actual rate of in-hospital complications. As volume increased, risk-adjusted complications showed a statistically significant decrease. Risk adjustment makes comparisons of clinical outcomes by hospital more valid and meaningful by accounting for sicker patients.

LOOKING AT THE NUMBER OF BARIATRIC PROCEDURES PERFORMED AND THE RATE OF IN-HOSPITAL COMPLICATIONS

Healthgrades Bariatric Surgery Report

From 2010 through 2012, across the states studied:

199,926

in-hospital bariatric procedures were performed, and

4.83%

of patients experienced one or more in-hospital complications

*Statistics based on analysis for three years for all-payer data (2010-2012) from 19 states where all-payer data was publicly available during any year(s) of the three year timeframe.

BMI AFFECTS COMPLICATIONS

Obesity in adults is defined as:

BMI \geq 30 kg/m²

Patients with a very high body mass index (BMI) have additional considerations including:

- The need for open versus laparoscopic surgery.
- BMI \geq 50 kg/m² (super obesity): greater risk of an unsuccessful surgical outcome.
- BMI \geq 60 kg/m² (super-super obesity): potentially longer surgery, recovery and follow-up times.

- Hospitals with the highest volume (defined as hospitals performing 375 cases or more during the three years of study) performed, as a group, statistically as expected, with the lowest rate of risk-adjusted in-hospital complications overall, and an actual-to-predicted ratio of 0.98 (2% fewer complications than predicted) (Table 4).
- Hospitals with the lowest volumes (defined as hospitals performing less than 75 cases during the three years of study) performed, as a group, statistically worse than expected, with the highest rate of risk-adjusted in-hospital complications and an actual-to-predicted ratio of 1.48 (48% more complications than predicted) (Table 4).

Table 4. In-Hospital Complication Rates by Volume of Procedures Performed

| Procedure Volume Range 2010–2012 | Total Cases of All Hospitals in Volume Range | Actual Rate of In-Hospital Complications | Predicted Rate of In-Hospital Complications | Actual-to-Predicted Ratio |
|----------------------------------|--|--|---|---------------------------|
| < 75 | 3,075 | 6.50% | 4.39% | 1.48 |
| 75–149 | 7,897 | 4.79% | 4.54% | 1.05 |
| 150–374 | 32,003 | 5.76% | 5.05% | 1.14 |
| 375+ | 121,373 | 4.85% | 4.91% | 0.98 |

Fewer Complications at 5-Star Rated Hospitals

After adjusting for patient risk factors, patients having bariatric surgery at hospitals with 5-star performance were, on average, 70.18% less likely to experience complications than patients having bariatric surgery at hospitals with 1-star performance and 45.45% less likely to experience complications compared to those with 3-star performance (Table 5). This means that if all hospitals performed at the level of hospitals with 5-star performance across the 17 states, 4,349 bariatric patients could have potentially avoided an in-hospital complication (Table 5).

Table 5. Bariatric Surgery Complications

| Hospital Bariatric Surgery Performance Rating | Actual In-Hospital Complication Rate | Predicted In-Hospital Complication Rate | Actual-to-Predicted Complication Ratio |
|--|--------------------------------------|---|--|
| 1-Star | 8.26% | 5.02% | 1.64 |
| 3-Star | 4.67% | 4.81% | 0.97 |
| 5-Star | 2.44% | 4.97% | 0.49 |
| 17 State Average | 4.83% | 4.83% | 1.00 |
| Relative Difference Between 5-Star Compared to 1-Star | | | 70.18% |
| Relative Difference Between 5-Star Compared to 3-Star | | | 45.45% |
| Complications Potentially Avoided If All Hospitals Performed at 5-Star Level | | | 4,349 |

HOW HEALTHGRADES EVALUATES HOSPITAL PERFORMANCE IN BARIATRIC SURGERY

Developing the Healthgrades Bariatric Surgery ratings involved four steps:

- The predicted number of complications was obtained for each hospital using logistic regression techniques.
- The predicted number of complications for each hospital was compared with the actual number of complications observed.
- A test was conducted to determine whether the difference between the predicted and actual figures was statistically significant.
- A hospital's performance was categorized into one of three performance categories based upon the outcome of the statistical test.

Healthgrades used the following performance categories:

- ★★★★★ **Better Than Expected** - Actual performance was better than predicted and the difference was statistically significant.
- ★★★ **As Expected** - Actual performance was not significantly different from what was predicted.
- ★ **Worse Than Expected** - Actual performance was worse than predicted and the difference was statistically significant.

Lastly, Healthgrades selected the top 10% of hospitals achieving a 5-star rating as Healthgrades Bariatric Surgery Excellence Award™ recipients.

For the 2014 model year, one year of data from Illinois and two years of data from California were used to develop the risk-adjustment model. Hospitals in these states were not evaluated given the lack of three continuous years of complete data.

For details on the methodology, see the Healthgrades *Bariatric Surgery Ratings 2014 Methodology*. For details on the award methodology, see the *Healthgrades Specialty Excellence Award™ Methodology*. You can find both methodologies at www.healthgrades.com/quality.

Improving Bariatric Surgery Outcomes

The potential benefits of bariatric surgery are numerous; however, all surgeries have risks. The short-term surgical and postoperative risks include breathing problems, hemorrhage (bleeding), infection, and death. Long-term risks include nutritional deficiencies and device complications requiring more surgery. In addition, obese patients often have other conditions, such as heart disease, high blood pressure, diabetes, and lung problems, which increase their surgical risks.

As a result, it is important for providers to ensure that only appropriate patients undergo weight loss surgery. Successful surgical results also depend on a patient's willingness to adopt ongoing lifestyle habits, including a long-term plan of healthy eating and regular physical activity.

To produce the best outcomes, it is critical that bariatric surgery programs:

- Ensure appropriate patient selection
- Identify and reduce (where possible) individual patient risks
- Have surgeons with adequate experience. Each surgeon should have performed at least 125 bariatric surgeries in his or her lifetime and a minimum of 50 cases in the last 12 months.⁴
- Have an overall 12-month facility volume of at least 80 cases

While Healthgrades findings did not show a difference in performance in complication rates between those hospitals with COE designation versus those without, there may be other value points associated with COE status for the hospital to consider in relation to other goals.

CONTACT INFORMATION

For questions on your hospital quality data, please contact marketing@healthgrades.com

For general questions about the **report**, please contact:

Sonja Baro
Director, Quality Products and Media
sbaro@healthgrades.com

For questions related to Healthgrades **methodologies**, please contact:

Susan Roughton, PhD, MHA
Director, Quality Measurement
sroughton@healthgrades.com

ACKNOWLEDGEMENTS

Contributors

Sonja Baro
Arshad Rahim, MD
Susan Roughton, PhD, MHA
William R. Wyatt, PhD, MSc.

Statistical Analysis

Alex Brown, MPE
William R. Wyatt, PhD, MSc.

Editors

Sonja Baro
Evan Marks
Susan McBratney, PhD
Carol Nicholas, MTC

Publishing

Carol Nicholas, MTC

Healthgrades

999 18th Street, Suite 600
Denver, Colorado 80202
www.healthgrades.com

REFERENCES

- 1 Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of obesity in the United States. 2009–2010. NCHS data brief, no 82. Hyattsville, MD: National Center for Health Statistics. 2012.
- 2 Finkelstein EA, et al. Obesity and Severe Obesity Forecasts Through 2030. *American Journal of Preventive Medicine*. 2012; 42(6): 563-570.
- 3 Dimick, JB., et al (2013) Before versus after implementation of a national policy restricting coverage to centers of excellence, *Journal of American Medical Association*, 309(8).
- 4 COEMBS Designation Requirements. Surgical Review Corporation. <http://www.surgicalreview.org/coembs/requirements/>. Accessed July 2, 2013. (SRC administers the COE program for ASMBS).
- 5 Carlin AM, et al: The Comparative Effectiveness of Sleeve Gastrectomy, Gastric Bypass, and Adjustable Gastric Banding Procedures for the Treatment of Morbid Obesity, *Annals of Surgery*, 2013 257(5) 791-797.
- 6 Poirier P, et al. Bariatric Surgery and Cardiovascular Risk Factors: A Scientific Statement from the American Heart Association. *Circulation*. 2011; 123: 1683-1701.
- 7 Screening for and Management of Obesity in Adults: U.S. Preventive Services Task Force Recommendation. [published online ahead of print June 26 2012]. *Annals of Internal Medicine*. 2012. <http://annals.org/article.aspx?articleid=1200996>.
- 8 Cremieux PY, et al. A Study on the Economic Impact of Bariatric Surgery. 2008; 14(9): 589-596.
- 9 Zhao, Y. (Social and Scientific Systems, Inc.), and Encinosa, W. (AHRQ). Bariatric Surgery Utilization and Outcomes in 1998 and 2004. Statistical Brief #23. January 2007. Agency for Healthcare Research and Quality, Rockville, Md. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb23.pdf>.
- 10 American Society for Metabolic and Bariatric Surgery Fact Sheets: Metabolic & Bariatric Surgery. Available at www.asmb.org. Accessed 6/22/2012.
- 11 Picot J, et al. The Clinical Effectiveness and Cost-Effectiveness of Bariatric (Weight Loss) Surgery for Obesity: a Systematic Review and Economic Evaluation. *Health Technology Assessment*. 2009; 13(41): 1-190, 215-357, iii-iv.
- 12 Gill RS, et al. Sleeve Gastrectomy and Type 2 Diabetes Mellitus: A Systematic Review. *Surgery for Obesity and Related Diseases*. 2010; 6(6): 707-713.
- 13 Nguyen NT, Paya M, Stevens CM, et al. The relationship between hospital volume and outcome in bariatric surgery at academic medical centers. *Ann Surg*. 2004 Oct;240(4):586-93. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1356460/>.
- 14 Banka G, et al. Laparoscopic vs Open Gastric Bypass Surgery: Differences in Patient Demographics, Safety, and Outcomes. *Archives of Surgery*. 2012; 147(6): 550-556.
- 15 Sudan R and Jacobs DO. Biliopancreatic Diversion with Duodenal Switch. *The Surgical Clinics of North America*. 2011; 91(6): 1281-1293, ix.

Healthgrades Bariatric Surgery Excellence Award™ Recipients 2014

The following hospitals are recipients of the Healthgrades Bariatric Surgery Excellence Award™ in 2014, indicating that they are among the best 10% of hospitals meeting minimum volume requirements. Some of the hospitals have multiple locations. In these cases, results for all locations were used in the analysis and each of the facilities is designated as a recipient of the award.

Table 6. Healthgrades Bariatric Surgery Excellence Award Recipients 2014

| State | Healthgrades Bariatric Surgery Excellence Award Recipients 2014 | City |
|------------------------------|---|-----------------|
| Alabama | Data not available to evaluate hospitals in this state | |
| Alaska | Data not available to evaluate hospitals in this state | |
| Arizona | Scottsdale Healthcare - Shea Medical Center | Scottsdale |
| Arkansas | Data not available to evaluate hospitals in this state | |
| California | Insufficient data available to evaluate hospitals in this state | |
| Colorado | No award recipients in this state | |
| Connecticut | Data not available to evaluate hospitals in this state | |
| Delaware | Data not available to evaluate hospitals in this state | |
| District of Columbia | Data not available to evaluate hospitals in this state | |
| Florida | Baptist Hospital | Pensacola |
| | Heart of Florida Regional Medical Center | Davenport |
| | Holy Cross Hospital | Fort Lauderdale |
| | Orlando Regional Medical Center | Orlando |
| | Including: South Seminole Hospital | Longwood |
| | Dr. P. Phillips Hospital | Orlando |
| | Orlando Regional Medical Center - Lucerne Pavilion | Orlando |
| | Sacred Heart Hospital | Pensacola |
| University of Miami Hospital | Miami | |
| Georgia | Data not available to evaluate hospitals in this state | |
| Hawaii | Data not available to evaluate hospitals in this state | |
| Idaho | Data not available to evaluate hospitals in this state | |
| Illinois | Insufficient data available to evaluate hospitals in this state | |
| Indiana | Data not available to evaluate hospitals in this state | |
| Iowa | No award recipients in this state | |
| Kansas | Data not available to evaluate hospitals in this state | |
| Kentucky | Data not available to evaluate hospitals in this state | |

| State | Healthgrades Bariatric Surgery Excellence Award Recipients 2014 | City |
|----------------|---|----------------|
| Louisiana | Data not available to evaluate hospitals in this state | |
| Maine | Data not available to evaluate hospitals in this state | |
| Maryland | Saint Agnes Hospital | Baltimore |
| Massachusetts | Newton - Wellesley Hospital | Newton |
| | UMass Memorial Medical Center - University Campus | Worcester |
| | Including: UMass Memorial Medical Center - Hahnemann | Worcester |
| | UMass Memorial Medical Center - Memorial Campus | Worcester |
| Michigan | Data not available to evaluate hospitals in this state | |
| Minnesota | Data not available to evaluate hospitals in this state | |
| Mississippi | Data not available to evaluate hospitals in this state | |
| Missouri | Data not available to evaluate hospitals in this state | |
| Montana | Data not available to evaluate hospitals in this state | |
| Nebraska | Data not available to evaluate hospitals in this state | |
| Nevada | Desert Springs Hospital Medical Center | Las Vegas |
| New Hampshire | Data not available to evaluate hospitals in this state | |
| New Jersey | Clara Maass Medical Center | Belleville |
| | HackensackUMC Mountainside | Montclair |
| | Southern Ocean Medical Center | Manahawkin |
| New Mexico | Data not available to evaluate hospitals in this state | |
| New York | Faxton St. Luke's Healthcare | Utica |
| | Highland Hospital | Rochester |
| | John T. Mather Memorial Hospital | Port Jefferson |
| | North Shore University Hospital | Manhasset |
| | Including: North Shore University Hospital Syosset | Syosset |
| | Saint Joseph's Hospital Health Center | Syracuse |
| North Carolina | Data not available to evaluate hospitals in this state | |
| North Dakota | Data not available to evaluate hospitals in this state | |
| Ohio | Data not available to evaluate hospitals in this state | |
| Oklahoma | Data not available to evaluate hospitals in this state | |
| Oregon | No award recipients in this state | |
| Pennsylvania | Barix Clinics of Pennsylvania | Langhorne |
| | Jeanes Hospital | Philadelphia |
| | Temple University Hospital | Philadelphia |
| | Including: Temple University Hospital - Episcopal | Philadelphia |
| | Western Pennsylvania Hospital | Pittsburgh |
| Rhode Island | No award recipients in this state | |

| State | Healthgrades Bariatric Surgery Excellence Award Recipients 2014 | City |
|-----------------------------|---|-------------|
| South Carolina | <i>Data not available to evaluate hospitals in this state</i> | |
| South Dakota | <i>Data not available to evaluate hospitals in this state</i> | |
| Tennessee | <i>Data not available to evaluate hospitals in this state</i> | |
| Texas | Baylor Medical Center at Trophy Club | Trophy Club |
| | Citizens Medical Center | Victoria |
| | Detar Hospital Navarro | Victoria |
| | <i>Including:</i> Detar Hospital North | Victoria |
| | First Street Hospital | Bellaire |
| | Foundation Surgical Hospital of San Antonio | San Antonio |
| | Laredo Medical Center | Laredo |
| | Las Palmas Medical Center | El Paso |
| | <i>Including:</i> Del Sol Medical Center | El Paso |
| | Memorial Hermann - Texas Medical Center | Houston |
| | Memorial Hermann Memorial City Medical Center | Houston |
| | The Physicians Centre Hospital | Bryan |
| | University General Hospital | Houston |
| | University Medical Center | Lubbock |
| | Victory Medical Center - San Antonio | San Antonio |
| Wise Regional Health System | Decatur | |
| Utah | <i>No award recipients in this state</i> | |
| Vermont | <i>Data not available to evaluate hospitals in this state</i> | |
| Virginia | Bon Secours - Maryview Medical Center | Portsmouth |
| | Inova Fair Oaks Hospital | Fairfax |
| | Sentara Careplex Hospital | Hampton |
| Washington | <i>No award recipients in this state</i> | |
| West Virginia | <i>Data not available to evaluate hospitals in this state</i> | |
| Wisconsin | Gundersen Lutheran Medical Center | La Crosse |
| | Ministry Saint Joseph's Hospital | Marshfield |
| Wyoming | <i>Data not available to evaluate hospitals in this state</i> | |