EMERSON’S CENTER FOR WEIGHT LOSS HAS SEEN IMPRESSIVE GROWTH

Service model and surgical expertise drive success

Thanks to David Lautz, MD, and Laura Doyon, MD, Emerson’s program has a reputation for not turning patients away.

Emerson’s highly regarded Center for Weight Loss is now the second largest program in Massachusetts in terms of bariatric surgery cases. According to David Lautz, MD, medical director, the service model has been designed to provide a state-of-the-art patient care experience. The program’s steady growth is also due to the surgeons’ expertise in performing a broad array of procedures, including revisions, which draws patients from well outside Emerson’s service area.

Prior to Dr. Lautz coming to Emerson in 2012, the annual volume of bariatric surgical cases performed was around 125. During FY 2019, the program performed 531 cases. Dr. Lautz and Laura Doyon, MD, who joined the program in

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WE’RE MAKING PROGRESS IN UPGRADING HOW WE COMMUNICATE

Barrett Tyler Kitch, MD, MPH
Senior Vice President of Clinical Affairs and Chief Medical Officer

For some time, Emerson has had a relatively complicated communication system. It has been harder to know who was on call, or how to reach them, than it should be, and the hospital has lacked a simple, standard way to contact physicians who have responsibility for care of patients in the hospital.

Moreover, the workarounds physicians and staff have developed using smartphones and texting, although understandable, are not optimal because of our need for secure communication. For example, standard texting is not secure. Fixing these communication issues represents real progress, which is what Renee Fosberg, vice president and chief information officer, and her team are working to achieve.

Their new communication system, called Vocera, will display provider on-call schedules and a directory that includes each physician’s preferred contact

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2015, agree that the success has resulted from Emerson’s investment in providing an excellent care experience and the center’s ability to provide advanced surgical treatment options. This includes primary bariatric surgical cases, but also complex revisional procedures on patients sent from other centers. “We take cases that many other centers are not comfortable doing, such as the revisions,” Dr. Lautz explains. “We get the full range: vertical banded gastroplasties [VBG] that need to be converted, fistulas from open bypasses that need to be taken down, patients with pain or ulcers that no one can figure out, etc.

“Many bariatric surgeons are uncomfortable doing revisions, which can be much more challenging technically than a primary procedure. Our approach is that, if you listen closely to the patient and take a hard look at their anatomy, you can almost always find a reason for their problem, find a solution and get them back on track.

“These patients come from all over the place, including the major Boston hospitals. I recently had a patient referred from Dartmouth Medical Center who developed an ulcer that would not heal despite 13 years of maximal medical therapy. With one operation, we were able to fix the ulcer and get that patient back to their life.”

The program has earned a reputation for not turning patients away. “For patients who need to lose more weight, we’ll tweak the patient’s medication and have them work with our dieticians,” notes Dr. Doyon. “We determine whether or not the sleeve gastrectomy or gastric bypass that was performed is functioning as it should, and what else we might offer to help them.”

The Center for Weight Loss also is welcoming additional patients since Shiva Gupta, MD, an experienced bariatrician (see page 6), recently began providing medically assisted weight loss treatment. For morbidly obese patients, surgery remains the definitive treatment, but for those who do not qualify or who are not interested in surgery, Dr. Gupta offers a comprehensive non-surgical approach.

“This year we have good medications for weight loss that can be very helpful,” she says. “I look carefully to see if the patient is taking any weight-promoting medications and recommend changes. I review and address all underlying factors for obesity, stress being a major one.”

Dr. Gupta is aware of the program’s success. “Their expertise in performing revisions is impressive,” she says. “But what I see in the surgeons is a passion to cure disease—not just perform more surgery.”

For some patients, the duodenal switch is the answer

For the past year, Dr. Lautz and Dr. Doyon have offered the duodenal switch to patients as a revisional option—typically to those who have had a sleeve gastrectomy, but also a gastric bypass. “In some patients, the metabolic effect of the original surgery wears off,” Dr. Lautz explains. “In those who are still very heavy, the best option can be to convert them to a duodenal switch, where we divert the duodenum to the ileum.”

Few programs in Massachusetts offer the duodenal switch. There are two reasons for that, says Dr. Doyon. “They are technically challenging, so Dr. Lautz and I often perform them together,” she says. “More serious vitamin deficiencies can be a long-term concern, so we do a complete assessment to make sure the patient had a pattern of good follow-up after their first surgery. We also do a lot of counseling to ensure that they are an appropriate candidate and will be compliant with close, long-term follow-up.”

There is no question the duodenal switch has a role to play in select patients, says Dr. Lautz. “Today many patients choose to

HOW WE COMMUNICATE

information. It is designed to cover all physicians who participate in the care of patients at the hospital. Earlier this year, Vocera was successfully launched in the surgical services department—the operating room, surgical day care, PACU, endoscopy and anesthesiology. Many of the clinical and support staff now wear badges that allow them to communicate in a hands-free manner, using voice-based commands and messaging, which streamlines workflow. Nursing supervisors use the Vocera application on their mobile phones to communicate with the surgical teams. We have received positive feedback on the Vocera system, which has resulted in notable improvements in productivity. The next phase will be to pilot secure texting for physician-to-physician communication. This work will begin in the next month and include a linking of the on-call directory to the secure texting app that physicians can install on their phones. Stay tuned for more communication developments aimed at delivering efficiency to the medical staff—and high-quality, safe care to our patients.
diagnose, stage and predict treatment response in prostate and bladder cancer. Instead of a chemotherapy response rate of 30-40 percent in bladder cancer, we hope to employ molecular markers in patient selection that bring it to 100 percent.

**You have an interest in bladder cancer and perform neo-bladder surgery.**

I was fortunate to do my residency at Lahey, where Dr. John Libertino was my mentor. I spent a year in the lab there studying bladder cancer with Dr. Ian Summerhayes, and this experience helped drive my interests in cancer biology research and urologic oncology. Bladder cancer provides a great model for the evolution of cancer and the genetic study of cancer in general.

Today virtually every patient asks me about bladder substitution when they are faced with having their bladder removed. It can be a real benefit in terms of their quality of life. We get many referrals of patients with hematuria, which is where the diagnosis and treatment of bladder cancer begins, as well as advanced cancer referrals from urologists outside Emerson.

**Your interest in bladder cancer extends to prevention.**

Yes. Smokers are at higher risk for bladder cancer. It makes sense to screen patients for hematuria, particularly if they have a heavy smoking history. We have conducted studies on the impact of ECGC, a nutrient found in green tea that was purified into pill form, and identified its beneficial biologic effects in patients’ bladder tumors. More research is needed to establish clinical efficacy, but these findings from early-stage studies are important in justifying larger-scale clinical cancer prevention trials.

**Given the complexity of some of your cases, you and your colleagues draw on the expertise of Emerson specialists.**

We do. A good example is a renal cancer case where tumor thrombi have grown into the vena cava. Dr. Libertino is a renowned renal cancer expert and pioneered the non-clamping partial nephrectomy. We perform these cases together, and we collaborate with our interventional radiologists, who perform angio-infarction prior to surgery so that we can safely remove the tumor and tumor thrombi. Emerson cardiologists provide us with intraoperative transesophageal ECHO monitoring. Our experienced pathologists are terrific as well; we often review slides together. Finally, Emerson has great PACU and ICU staff who take care of these complex patients. As a result, we’ve had excellent outcomes.

**Any advances in the field of urology?**

Some of the newer imaging modalities will add a new dimension to our diagnostic capabilities. We routinely utilize F-18 PET scanning, which is important for diagnosing recurrent prostate cancer. We also have MRI-targeted biopsy capability, in which we overlay MRI imaging onto our live ultrasound imaging to target high-risk prostate lesions. Our anesthesiologists use esophageal doppler for hemodynamic monitoring, which is a great advance in intraoperative monitoring.

I’m happy to report that the urology department is consolidating our offices on the second floor of the John Cuming Building, next to the Mass General Cancer Center oncology staff. This will make it easy to review cases with our medical and radiation oncology colleagues. Emerson pathologists and radiologists participate in the presentation and review of these cases as well. Our goal is to provide the multidisciplinary care that makes cancer centers great.

**What do you enjoy during time off?**

Our family takes trips around New England and New York—to Maine, Nantucket and Niagara Falls—and to Tanglewood. Music is a favorite pastime; I play French horn. Our son plays cello with the New England Conservatory Prep Orchestra, and our daughters play clarinet and trumpet in their school band.
have the sleeve gastrectomy and later find they want to, and need to, go further with their weight loss, or we may see a bypass patient who has lost a lot of weight but still has a BMI of 50 with reasonable anatomy. For them, the best results are seen when they are converted to a duodenal switch.”

The important thing is for patients to receive treatment that returns them to health. “The evidence is clear that some people have a metabolism that is resistant to weight loss through diet and exercise,” says Dr. Doyon, who is board-certified in obesity medicine. “Because being overweight or obese has been normalized, patients with a BMI of 35 often say ‘I didn’t think I was a candidate for surgery.’”

Reputation is strong among patients

Taking the time to design a weight loss program that supports patients—every step of the way—has created strong word of mouth in the region, says Dr. Lautz. “When I came here, Emerson really committed the resources to practice this specialty as it should be done, including redesigning our clinic space to accommodate patients of size. They allowed us to recruit a fantastic team and have them all in one location, which is much more functional for the patients, who have their own busy schedules.

“Our patients are on the same floor while in the hospital so that we can work closely with those nurses. This directly improves safety. As a result, our patients have a care experience, before and after surgery, that I believe is unrivaled in New England. The ability to offer Dr. Gupta’s expertise to non-surgical patients is the latest example of that commitment from Emerson.”

Patients who come to Emerson see progress. Those who attend the regular weight loss info sessions can pose questions directly to Dr. Doyon or Dr. Lautz. Once they join the program, they meet their surgeon right away, and things move along. “We often hear patients describe how they got stuck in the pre-op process at another program—sometimes for months, which doesn’t make sense,” says Dr. Doyon. “Once they make the decision to get serious help for their weight, it’s important that we move them toward their goal at a reasonable pace.”

Patients have regular contact with a patient navigator and a mental health coordinator, and they are encouraged to attend the bariatric surgery support groups. When patients return for appointments, the front desk staff welcomes them and remembers their names. “Of all the things we’ve done at Emerson, the team we’ve built is what I am the most proud of,” says Dr. Lautz. “I get compliments on them all the time from patients.”
The new reimbursement model for home care that becomes effective on January 1, 2020 has been called “the most significant regulatory and reimbursement reform since the creation of the Prospective Payment System.” The Patient-Driven Groupings Model (PDGM) required by the Bipartisan Budget Act of 2018 is designed to improve reimbursement for those who are eligible for home health benefits and simultaneously remove incentives to over-provide therapy services.

“PDGM represents the biggest change in home care in the last 20 years,” says Christine Dixon, RN, MMHC, executive director of Emerson Hospital Home Care. “We ask that physicians focus on the two main areas that require their attention. First, PDGM requires a specific diagnosis for each patient. As a result, symptom codes—R codes under ICD-10—and many unspecified codes are no longer considered to be valid.

“Writing that the patient has weakness to request a PT evaluation is no longer acceptable,” Ms. Dixon explains. “The underlying medical condition causing the weakness must be on the order.” (See chart.)

Second, because the new billing period is changing from 60 days to 30 days, orders must be returned, and signed by the physician, in a much tighter timeframe in order to bill for home health services. Signed orders can only come from a physician—not a PA, NP or CNM. “This is important. If we do not receive the orders back on time, we cannot bill, which will have an impact on our clinical operations. This is a challenge for Emerson Hospital Home Care.”

The bottom line is clear. “The pressure is on for us to have what we need upfront for patients who require home care: complete documentation, including the skilled services, specific diagnosis for home care and face-to-face encounters signed by the physician.”

During the transition to PDGM, please keep in mind:

• Review, sign, date and time orders quickly.

• Let Emerson Hospital Home Care know the most efficient way to exchange information: fax, email or send a hard copy of the orders.

• Consider designating someone in your office as a liaison to home health care to promote continuity and reduce delays in patient care.
SHIVA GUPTA, MD, BRINGS MEDICALLY ASSISTED WEIGHT LOSS TO EMERSON

Shiva Gupta, MD, recently joined the Center for Weight Loss in order to provide medically assisted weight loss services. Many patients who need to lose weight either do not qualify for bariatric surgery or wish to avoid surgery. According to Dr. Gupta, today there is more to offer these individuals.

“Over the past 20 years, since the discovery of leptin, the first satiety hormone, a lot has been learned about the neuro-hormonal pathophysiology of weight control, which has allowed research to be directed to developing drugs targeted to specific appetite control mechanisms,” she notes. “We understand obesity better, including that it is a multi-factorial, chronic condition.”

Dr. Gupta was in practice as a primary care physician for many years and understands the challenges of treating obesity. “Our medical training didn’t address obesity,” she says. “Quality measures now require reporting BMI. However, there are no clear guidelines regarding intervention. As a result, obesity is under-diagnosed and under-treated.”

Before joining Emerson, she served as medical director of Tufts Medical Center Community Care in Woburn, where she had primary care and bariatrician practices. Dr. Gupta also served as a hospitalist in Massachusetts and Illinois medical facilities. She has an impressive background in quality and growth initiatives, as well as utilization management.

Dr. Gupta received her medical degree from SMS Medical College in Jaipur, India, and completed her residency training at Saint Joseph Hospital in Chicago, which is affiliated with Northwestern University Medical School. She is board-certified in internal medicine and obesity medicine.

To reach Dr. Gupta or to make a referral, please call the Center for Weight Loss at 978-287-3532 or contact her at shgupta@emersonhosp.org.

LEADERSHIP DONOR RECEPTION HELD IN NOVEMBER

More than 100 of Emerson’s leading philanthropic supporters gathered for the annual Leadership Donor Reception at the home of Jeff and Sarah Newton in Concord. Attendees included (right to left) Deborah Greene, MD, associate chair of the Emergency Department and a member of the Emerson Health Care Foundation Board of Directors; Bob Puffer, a corporator who represents Acton; and his wife, Jane.

clinical pearls

Submitted by Sravanthi Madala, MD
Emerson Endocrinology Associates

Patients who are on long-term, daily systemic corticosteroid therapy should be screened for osteoporosis, as they are at higher risk for rapid bone loss. In fact, this can occur within the first three months of treatment. For example, patients with rheumatologic disease, pulmonary conditions and autoimmune disorders often take daily prednisone. Their risk for a fracture is increased by 15-20 percent. Even if someone is screened and found to have osteopenia—not osteoporosis—they still are at risk for a fracture. Medication dose matters; a patient who is on 5 mg or greater of prednisone equivalent/day for three months, or if there has been a cumulative dose of 5g of prednisone/equivalent over the past year, should have bone-density testing. I encourage physicians to use the FRAX® fracture risk assessment tool, which was developed at the University of Sheffield as a way to evaluate fracture risk in patients. It is based on patient models that integrate clinical risk factors and predicts the probability that a patient will experience an osteoporotic fracture during the next ten years. Fracture risk for those on steroids should be increased by a multiplier of 15-20 percent. Visit sheffield.ac.uk to download the FRAX application.

Dr. Madala can be reached at SMadala@emersonhosp.org or 978-287-8520.