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Caring Is Purpose in Life for 2018 Medical Director of the Year

Joanne Kaldy

Eric Hasemeier, DO, CMD, is one of those rare individuals who from an early age has sought after his purpose in life. He always felt an obligation to help others and to make a difference in people's lives.

"I've found my niche and purpose in life. This is my dream job," said Dr. Hasemeier, chief executive officer and founder of Dr. Hasemeier and Associates. The work he loves makes a powerful difference, and that is why he is AMDA – the Society for Post-Acute and Long-Term Care Medicine's 2018 Medical Director of the Year. Dr. Hasemeier is also the first osteopathic physician to receive this prestigious award.

Photo courtesy of Eric Hasemeier

Eric Hasemeier's career as a medical director started with engineering, moved through academia and private practice, and survived a couple of devastating hurricanes until he finally settled down in Tennessee.

Winding Road Leads to Home

Dr. Hasemeier's road to Medical Director of the Year has been a long but interesting one. "I have a very unusual background," he admitted. He told *Caring* he felt an obligation to others and a need to make a difference in people's lives. Gifted in math and science, he was always interested in medicine.

However, he pursued engineering to please his father. As an industrial engineer, Dr. Hasemeier helped hospital facilities to increase their efficiency. During this time, he got an opportunity to become a hospital administrator, and he jumped at the chance. For 9 years, he was a successful administrator moving forward on a positive career path, but he was restless and — with his wife's urging — decided it was time to fulfill his own dream of becoming a physician.

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Society Weighs in on Proposed Budget

The Trump administration recently released its fiscal year (FY) 2019 budget. The budget signifies the Administration's priorities and can set the stage for future policymaking by Congress. Congress' process for federal spending for FY 2019, which begins on Oct. 1, 2018, would normally include a budget resolution to set topline spending numbers, but that is not expected to occur this year. Instead, the bipartisan budget deal that was recently reached will set the topline numbers for the Appropriations Committees to work from as they craft the appropriations bills.

There are several provisions of interest to AMDA – the Society for Post-Acute and Long-Term Care Medicine, as described by the Health and Human Services Budget in brief, which routinely accompanies the budget:

MIPS. The budget proposes in FY 2021 to simplify the Merit-based Incentive Payment System (MIPS) by adopting broader claims and beneficiary survey calculated measures that assess clinician performance on quality and cost during the performance period at the group-level only. Pay adjustments would also apply only to services in the physician fee schedule rather than all Part B payments. This proposal provides the HHS Secretary with authority to set the MIPS performance threshold during the 2019-2020 transition years.

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When Dr. Hasemeier was accepted to medical school, he recalled, "My father thought I had lost my mind. He didn't understand why I would give up a good-paying job with opportunities for advancement to become a physician." But Dr. Hasemeier had made his decision, and he never looked back.

After medical school he wanted to practice somewhere that "really needed a doctor," he said. He landed in a West Virginia paper mill town with 3,000 people. "I was the first town doctor they had ever had. I loved it," he said. But the small rural community wasn't the best fit for his family, so he knew it was time to move on. He took a position as associate dean of a medical school, but he became disillusioned with academic life, and he longed to return to direct patient care.

Dr. Hasemeier and his family uprooted and moved to Florida. Working in private practice was very satisfying at first, but a comfortable life that many would envy ultimately didn't bring him contentment. He had a wake-up call in 2004 when Hurricane Ivan destroyed his family's home.

"We lost everything, so we moved inland and tried to rebuild our lives," he said. "Then the next year Hurricane Dennis came along and caused massive devastation. We knew we were blessed and only lost possessions and not our lives. After this experience, we decided to move to Tennessee in 2006." Dr. Hasemeier started over in private practice and quickly got involved in nursing home care again, which he thoroughly enjoyed and felt like it was the perfect fit.

After making the decision to phase out office-based care and focus exclusively on the nursing home setting, Dr. Hasemeier said, "I have never been happier. I don't want to do anything differently than what I'm doing right now. Every morning, I get up and look forward to going to work. I love what I do."

Study: Diabetes Monitoring Falls Short in Individuals With Alzheimer's Disease and Related Syndromes

Christine Kilgore

Individuals with Alzheimer's disease and related syndromes (ADRS) were significantly less likely to receive basic diabetes monitoring — and were more likely to experience diabetes complications — than those without ADRS in a longitudinal observational study in France.

Those with ADRS were more frequently hospitalized for diabetes-related conditions, particularly for coma (a 3-fold to 9-fold increased risk) and ketoacidosis without coma, but also for nephropathy and neuropathy, according to Matthieu Wargny, MD, MSc, of the University Hospital of Toulouse, and his coinvestigators. "Our study questions [the] health care quality offered to people with dementia," they said.

ADRS can compromise patients' diabetes self-care and monitoring abilities, making management more challenging, and ADRS may itself lower diabetes prioritization in individuals with multimorbidity. The authors noted a lack of specific guidelines available regarding the frequency of glycated hemoglobin A1c testing in older adults with ADRS [*J Am Med Dir Assoc,* Jan. 25, 2018; doi:10.1016/j.jamda.2017.12.006]. (*Note:* AMDA – the Society for Post-Acute and Long-Term Care Medicine offers a Clinical Practice Guideline for diabetes and developed a position statement in 2016 on diabetes care in long-term care and skilled nursing facilities.)

The study followed a cohort of individuals 65 or older who were identified through the French national health insurance database as having incident ADRS, and they were matched 1:1 based on age, sex, residence area, and insurance scheme with beneficiaries without any ADRS criteria. ADRS was defined by the first recording of 1) registration in a long-term disease registry for ADRS; 2) hospitalization reporting a diagnosis code of ADRS; or 3) reimbursement for at least one acetylcholinesterase inhibitor or memantine.

The individuals selected for the study had their first ADRS criterion in 2011 or 2012 and diabetes mellitus that was identified at least 2 years before ADRS identification. The 87,816 ADRS participants and non-ADRS matched patients were evaluated for 3 years — comprising the year before the index date of ADRS identification/diagnosis and the following 2 years.

HbA1c determination was less frequent in the ADRS group during each yearly period. During the year before the index date, 82.5% and 88.5% of the ADRS and non-ADRS groups, respectively, had at least one HbA1c test. The difference worsened during year 1 after the index date — with 73.4% and 89% of the ADRS and non-ADRS groups, respectively, receiving HbA1c tests; the difference remained stable during year 2. The analysis of those receiving two or more HbA1c tests a year found similar patterns.

Although the number of general practitioner consultations per year was similar when comparing the ADRS and non-ADRS groups, the ADRS group was significantly less likely to have at least one annual lipid profile, annual microalbuminuria test, or eye examination; however, that might not necessarily be indicators of poor care. The lower rate of monitoring worsened with time, and the difference was still evident in "conservative" sensitivity analyses that excluded the frailest individuals.

Individuals with ADRS were also consistently more frequently hospitalized for diabetes-related complications. During the year before the index date, there were 72 cases of at least one hospitalization related to diabetes per 1,000 person-years in the ADRS group compared with 35 cases per 1,000 person-years in the non-ADRS group — for an age-standardized incidence ratio (SIR) of 2.04. The SIR rose to 3.14 during year 1 and decreased to 1.67 during year 2 after ADRS identification.

Regarding hospitalization for ketoacidosis without coma, the incidence during the year before the index date was 3.1 cases per 1,000 person-years for the ADRS group and 0.6 cases per 1,000 person-years for the non-ADRS group (SIR of 4.70). The SIR was 7.78 and 2.66 during the first and second years after ADRS diagnosis.

Similar trends were seen for hospitalizations for diabetes-related coma. The incidence was 4.9 cases per 1,000 person-years in the ADRS group versus 3.2 cases per 1,000 in the non-ADRS group, for SIR values of 3.84, 9.30, and 3.06 for each successive year. "The results concerning hospitalizations for life-threatening and preventable events such as diabetic coma are particularly alarming," the investigators said, noting that their study is not the first to suggest an increased risk of diabetes-related hospitalizations among individuals with ADRS.

In a sensitivity analysis that excluded individuals for whom ADRS was first identified during a hospital stay, the magnitude of the SIR was reduced, especially for the first year after identification. However, "individuals with ADRS remained significantly more likely to undergo every studied hospitalization than individuals without ADRS," the investigators said.

Diabetes was identified by registration through France's long-term disease registry system, which the investigators said is prevalently used and "expected to be very specific." It is important to note, however, that the study did not clinically ascertain the diabetes and ADRS diagnoses, and the ADRS index date likely did not represent the date of first symptoms. Also, health insurance data in the national registry do not include all procedures performed for inpatients, which could mean that not all biological tests or eye examinations were entered in the database.

The investigators also could not distinguish between community-dwelling individuals and individuals living in nursing homes, which they noted "would have been interesting to study." Nor did they have information on ADRS or disease severity. The severity of dementia, and the presence of cardiovascular disease and other complications, might suggest function and prognosis could be significantly different in individuals with ADRS in the community, compared with residents with ADRS in nursing homes.

PA/LTC COMMENT

Current guidelines and position statements do provide guidance on not only the frequency of A1c testing, but also its inappropriateness in certain populations (short-term rehab patients transferred from acute care, and patients at the end of life), individualized glycemic goals, selection of pharmacotherapeutic agents, and strategies to avoid hypoglycemia as well as extreme hyperglycemia. Hypoglycemia is known to worsen cognitive impairment, and cognitive impairment is related to more frequent episodes of hypoglycemia, thus supporting a bidirectional relationship.

Although adverse clinical outcomes and hospitalizations for systemic inflammatory response syndrome and coma were more frequent in the ADRS subjects, the parity in the number of general practitioner (GP) consultations presents an opportunity. Individuals with diabetes and ADRS could be screened more closely by GPs for hypoglycemia, weight loss, early functional decline, frailty, depression, and the development of foot problems, heart failure, or renal failure. In addition, GPs would be able to identify failure of existing services and supports, and the need for palliative and end-of-life care. Such visits could be used to identify goals of care, and potentially avoid complex hospitalizations.

—Naushira Pandya, MD, CMD

Christine Kilgore is a freelance writer in Falls Church, VA.

Survey Says

Dr. Hasemeier, a medical director for eight long-term care facilities in Tennessee, has extensive knowledge of survey regulations — he keeps a copy in his car — and is able to show surveyors how the facility is in compliance.

Dr. Hasemeier participates in his facilities' surveys, and he meets with the surveyors to address their questions. "I simply introduce myself and give them my cell phone number. I try to establish a cordial relationship. If they have questions, I do my best to give them the answers." For instance, he noted that they often may not understand why a specific care decision or treatment choice was made, and he can help explain how the facility did everything to meet the standard of care and provide proper patient care.

"The surveyors follow the regulations, so having a knowledge of them myself helps tremendously," he said. Thanks to these efforts, he has helped more than one facility become deficiency-free, and has established positive relationships with the surveyors in his state, who know him as a source of honest, accurate information.

Quality Improvement

Dr. Hasemeier's engineering training made him a natural at addressing quality issues. "I was trained in improving processes, and that ties right into quality improvement," he said. For instance, he recognized that a medical checklist could help nurses understand when to get a urinalysis (UA) and when this task is unnecessary or inappropriate.

"I created a form that had to be checked off before you even get a urine sample," he told *Caring*. Nurses received education and training on the medical form, and "they got behind it and became great patient advocates," Dr. Hasemeier said. "Implementing this checklist has worked very well, reducing unnecessary UAs and the use of antibiotics by 50%. We also saw a big drop in [*Clostridium difficile*] infections. We're trying to extend this to other types of infections such as pneumonia. We really need to know if it actually is pneumonia before we put people on antibiotics. We ask a lot of in-depth questions before we start antibiotics."

Dr. Hasemeier also established gradual dose-reduction efforts for antipsychotics and anxiolytics that have reduced the percentage of patients using these drugs from more than 50% to less than 10%.

Quality improvement is an ongoing concern for Dr. Hasemeier. "You should be constantly monitoring all factors that go into a 5-Star rating," he said. "You can't just look at 3 months' worth of data to identify trends. We look at each quality measure and the last 12 months of data to track trends."

Teaching That Resonates

Dr. Hasemeier shared his methods as a successful teacher. "First of all, I have to do a lot of selling. I have to help people understand why something is the right thing to do. It has been shown over and over that if you educate people and show the reason behind what you are saying and what you are asking them to do, they will have greater understanding and will more likely follow through on your request." He said that he dials down the technical terminology and takes time to make sure his audience understands.

He also welcomes opportunities to speak at a variety of programs, conferences, and meetings. "I especially enjoy talking to community groups about Alzheimer's disease, helping people get the facts and better understand the progression of the disease and what lifestyle changes they can make to stay healthier longer," Dr. Hasemeier said.

Although he enjoys talking to groups, he is just as appreciative of opportunities to teach one on one. For example, he often takes time with residents' family members. "I try to enable them to make educated decisions. I will sit down and say, 'Let's talk about where we are and what is going on with your loved one.' I try to be realistic but empathetic, and give them the information they need to make an informed decision."

The Society Connection

To receive an award recognizing his accomplishments as a medical director is rewarding in itself, but to receive it from the Society means even more, Dr. Hasemeier said.

"My membership has helped me become an informed physician in the nursing home environment. Before I found the Society, I really didn't completely understand this practice setting," Dr. Hasemeier said, adding that the Society and its members opened up to him a "whole world of information and knowledge."

"I never miss an annual conference. I buy and listen to the CDs to continue my education afterwards. The Society provides so much education and training that is invaluable to my work. I would be lost without it," Dr. Hasemeier said.

Caring for the Ages congratulates Dr. Hasemeier on his achievement.

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