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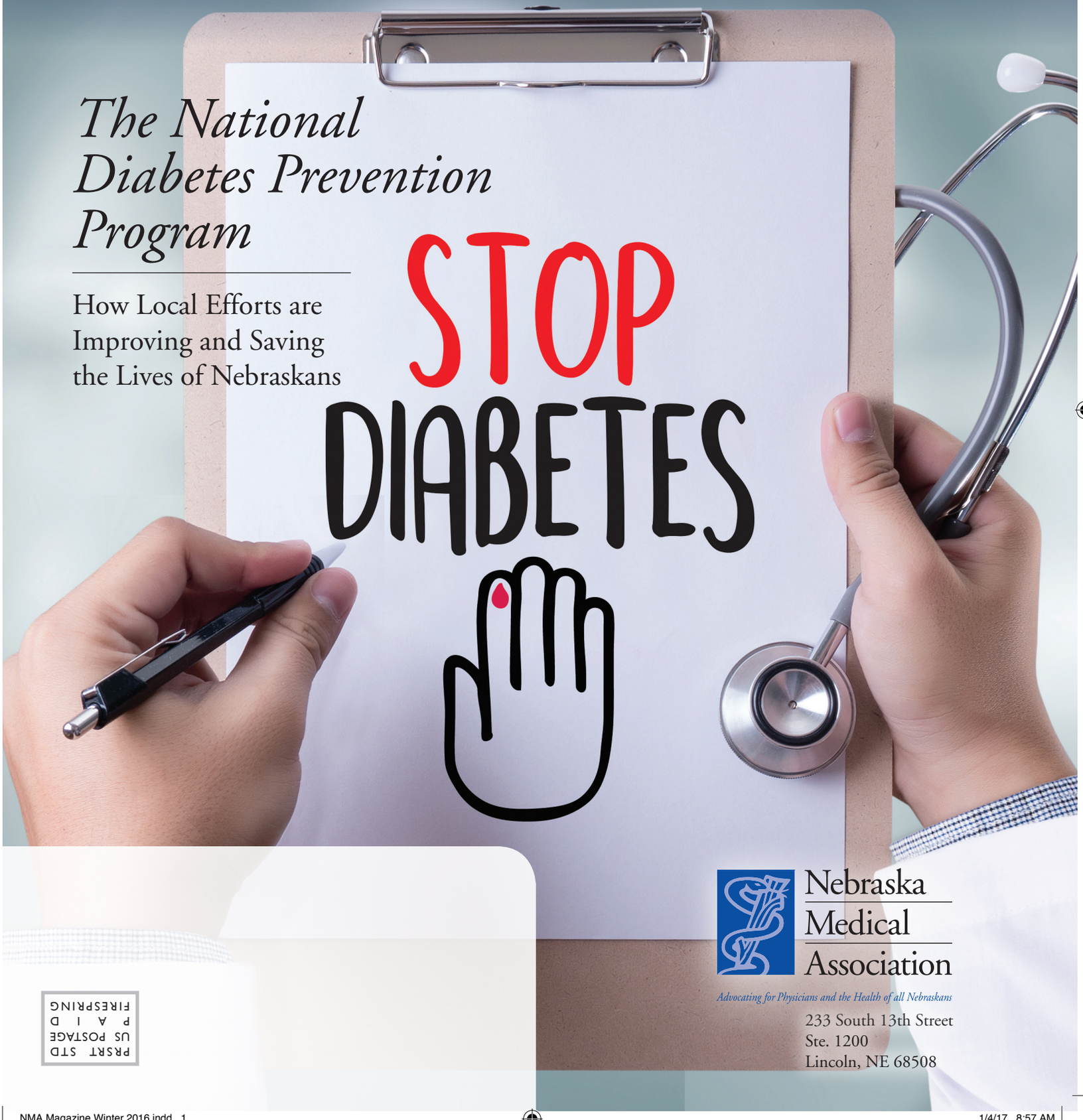

The National Diabetes Prevention Program

How Local Efforts are Improving and Saving the Lives of Nebraskans

Nebraska Medical Association

Advocating for Physicians and the Health of all Nebraskans

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President's Message

by Todd Pankratz, MD
NMA President

I hope that all of you had a wonderful holiday season. The beginning of the year welcomes a new legislative session. I would like to personally invite anyone who is interested in being involved in this year's legislative efforts to join the NMA as a legislative advocate. Whether it's an issue near and dear to you or a timely concern of yours, please let us know what is on your mind in regards to the future of medical care and the Nebraska Medical Association.

The NMA's calendar of events is full of activity this year. In December, the NMA, along with several other health care entities, hosted Healthcare 101 for all the new legislative senators. This was a great way to introduce our new senators to the major issues affecting our members, including educating them on the importance of the Nebraska's Hospital-Medical Liability Act and related malpractice issues, and current topics such as medical marijuana, the motorcycle helmet repeal bill and other public health measures.

On January 24, we will host our annual advocacy breakfast at the Capitol. I would encourage all NMA members to attend if possible. This is an outstanding opportunity to make contact with our state senators and discuss current and future bills. The breakfast will begin at 7:45 and conclude around 9:00 a.m. Even if you cannot stay the entire time, it's beneficial to stop by and make connections with your senator and others in the legislative body. There are many new faces in our legislative body; some of these senators I know personally which gives me the ability to interact with them and share Nebraska Medical Association concerns with them. Without an established relationship, this can be more difficult to do. We would also ask for everyone's support as bills come up before committees and the body. Please be willing to testify, write a letter or call your senator. As physicians it can be at times very difficult to balance our practice, patients and our personal lives, but there is opportunity for everyone to take a turn. The NMA staff is always willing to provide assistance.

Among our regular committees and commissions, our medical home and prescription drug monitoring program committees will be busy in 2017. We will also continue to meet regularly with our specialty/subspecialty committee to address issues of importance to our specialist groups. If you are interested in being involved, reach out to NMA staff.

Other items we are excited about are our 2017 Webinar Series and the debut of a new website towards the middle of the year. Our webinar series, which will begin in March, will cover topics including blood management, sepsis, palliative care, physician burnout and HPV. These will include free CME credits for all NMA members.

Again, I hope you all had a happy and healthy holiday season. As always, thank you for your membership and participation in the Nebraska Medical Association. □

Executive Vice President's Message

by Dale Mahlman
NMA Executive Vice President

November 8, 2016, delivered a message to us all: change is in the air!! Whether that be at the state or national level, the electorate has spoken and the results are final.

At the national level, the White House will be held by perhaps the biggest political longshot in recent years, intent on "Making American Great Again." When I think of the numerous candidates that were on the stage at the initial Republican debate in Cleveland, President-elect Trump clearly offered the most "change" from tradition and the status quo. And over the other nine candidates filling the stage with him that night, he clearly provided the most sound bites.

As the campaign progressed, it was obvious change was a key component in both parties' march to the White House with Senator Bernie Sanders preaching his "revolution" to his supporters as proof significant change was encouraged as a platform.

When the campaign headed for the national conventions, change was still in the air as our current President was down to his last six months in office. The media remained fixated on the two candidates and the voting public continued to hunger for "change."

On January 20, 2017, the new party of change will take the keys to the White House. We are all hoping for a prosperous and successful term for Donald Trump, whether we voted for him or not.

At the state level, November 8 signaled to us change as well as 17 new state senators were elected to office with three incumbent senators defeated in re-election efforts. This state election saw more involvement by the Governor's office than recent elections; our new Unicameral (which began January 4, 2017) will be an interesting mix of young and old, new and returning senators. Apparently, exactly what term-limit legislation was intended to provide.

This 105th Legislature will immediately vote to elect a new Speaker and committee chairs. They will then begin to address a $900 million projected revenue shortfall. In our preparation for the upcoming session, we remain aware of the financial condition of the state budget and are mindful that potential legislation not have a fiscal note of significance attached to it. That being said, to create "change" at the state level might also require an initial investment of funds to get things rolling.

At the Nebraska Medical Association, we like to pride ourselves on our ability to "adapt to change," something that will be tested now more than ever at both the state and national level. We are comfortable with change and communicating that change to our membership, primary care and specialists, employed or independently practicing physicians. Do we have any idea what the upcoming change will be or how it will impact our daily activities? No, but the NMA and our members stand ready to take on the challenge. We continue to speak with our colleagues in the health care arena, communicating our priorities so together we can collaborate whenever possible to increase our effectiveness. We continue to urge our membership to be active and informed and do all we can to make that effort easier and more understandable.

What can you do to be an agent of change in the months ahead? Get informed and get involved. We have many ways to increase your knowledge of the issues facing medicine. If you can't find what you are looking for, give us a call or send us an email. We need your support, both financially and actively, to continue to "Advocate for Physicians and the Health of all Nebraskans" in the rapidly changing world in which we live. Can we count on you to continue to support the NMA and your profession? □

Diabetes Prevention—Early Intervention in Prediabetes, a New Frontier of Opportunity

by Kevin Nohner MD, MBA
Omaha

In the 30 years of my family medicine practice, I have been able to witness many technologic improvements that have enabled earlier detection of illnesses with life altering results. Advances in mammography leading to earlier detection of breast cancer, angiographic and non-invasive cardiac techniques improving both outcomes and decreasing procedural risks, and acceptance of screening colonoscopies by insurers allowing reduction in colon cancers by an amazing 80-90 percent are just a few of the examples. However, despite advances in medicine, obesity and diabetes continue to be major health problems across the United States and the numbers of patients afflicted continues to grow. Developments of new medications have provided us with a multitude of diabetic treatment options but, once a patient has become diabetic, preventing their complications becomes more and more difficult. Despite a decrease in the percentage of complications, the prevalence of complications has continued to grow due to the increasing number of diabetics. Subsequently, the cost of care to treat diabetes climbs steadily—leading to physical, mental health and quality of life issues. Even with the best intended plans, patient compliance, engagement and social economic factors can affect outcomes significantly.

A major step to combat this growing epidemic was achieved when Congress authorized the Centers for Disease Control (CDC) to develop the National Diabetes Prevention Program (NDPP) and provided grants to fund public health departments/engaged participants participating in CDC recognized NDPP programs and pilot studies. Focus has now shifted to educating patients and healthcare providers in regard to the program—starting in 2014-15 with 11 states and Nebraska and seven other states in 2016.

Interested stakeholders, the Nebraska Medical Association included, participated in a State of Nebraska Engagement Meeting August 24-25 in Lincoln to develop a strategic plan to raise awareness and promote utilization of the program. This issue of the Nebraska Medical Association magazine will introduce you to the NDPP, a joint effort by the CDC and American Medical Association (AMA). Physicians can utilize the NDPP as a tool to significantly delay or prevent progression of pre-diabetes to diabetes in our patient practices. How many people does this affect? What kinds of an impact are we looking at? Why put the effort into it? The CDC and other information sources cite:

- 86 million adults have pre-diabetes, with estimates that one third of patients over age 18 and one half of those over age 65 have prediabetes
- 9 out of 10 people with pre-diabetes do not know they have it and often have less (if any) effective medical interventions suggested as part of their care plan

- 15-30 percent of people with pre-diabetes develop type 2 diabetes within five years
- The yearly incidence of type 2 diabetes rises from ~1 percent in the general adult population up to 5-10 percent if prediabetes has been diagnosed
- In the next five years, a typical medical practice is projected to experience a 32 percent increase in patients with type 2 diabetes
- Prediabetics who participated in the initial three-year lifestyle intervention diabetes prevention program showed a 58 percent reduction in the number of new cases of diabetes overall and a 71 percent reduction in for those over age 60 (compared to 31 percent if given metformin)
- At 15 years the incidence of diabetes was still 27 percent lower in NDPP participants, and the median delay of the onset of diabetes was four years
- On average, the cost of care to complete the NDPP course per patient is ~ $450, with expenditures reduced approximately $2700 for each of the first three years if conversion to diabetes is prevented [1]

Currently there are a total of 33 programs in Nebraska: 29 across the state, one in Lincoln, and three in Omaha. Funding and cost are an issue at present. However, some insurers

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American Association of Diabetes Educator's Model for the National Diabetes Prevention Program

by Joanna Craver DiBenedetto, BS, MNM
Director of Prevention, AADE

Type 2 diabetes continues to be an epidemic in our country, costing billions of dollars and affecting the majority of our population. Prediabetes, as a defined category of blood-based values, is a precursor to type 2 diabetes. Those with prediabetes and other contributing factors are at high risk and very high risk for developing type 2 diabetes, but now have a viable option to prevent or delay the progression of the disease.

A research study by the National Institutes of Health on the Diabetes Prevention Program (DPP) clearly demonstrates its effectiveness in preventing or delaying type 2 diabetes, comparing an intensive behavioral lifestyle change program to metformin and a placebo group. Further translational studies of this DPP lifestyle change program included a cost-effective model for delivering a group-based version of the DPP, in partnership with the YMCA, and after evaluated, was found to have similar positive outcomes. The success of this program—in combination with awareness of the increasing prevalence of type 2 diabetes and its economic ramifications—likely contributed to authorization in the Affordable Care Act for the Center for Disease Control and Prevention (CDC) to establish the National DPP, which resulted in the CDC's 2012 issuance of the *Funding Opportunity Announcement for Preventing Type 2 Diabetes Among People at High Risk.*

The American Association of Diabetes Educators (AADE) was chosen to enter into a cooperative agreement with the CDC in 2012 to expand access to and reimbursement for people at high risk for developing type 2 diabetes by scaling the CDC led, evidence-based National Diabetes Prevention Program (DPP) within AADE's established network of diabetes educators and accredited diabetes education programs. The objective of the CDC is to promote access to, referral of and enrollment in the National DPP as a covered health care benefit, ensuring the program is delivered with quality and is available to all eligible participants. Through this work over the past four years, AADE has developed a viable model called "AADE DPP," to meet CDC's goals of the National DPP. The AADE DPP model utilizes the existing network and infrastructure of thousands of AADE and American Diabetes Association (ADA) nationally certified Diabetes Self-Management Education (DSME) programs and their staff.

Currently, there are approximately 3,200 nationally certified DSME programs represented in all 50 states that are eligible to bill Medicare for diabetes education services. Each program may also have multiple satellite locations. Therefore, the potential footprint and infrastructure of the AADE DPP model to increase access for millions of people with prediabetes who are eligible for this program is already established.

All nationally certified DSME programs are required to be HIPPA compliant, participate in audits, engage in physician referral systems and acquire an NPI number. Programs also have the ability to bill directly. All AADE DPP sites are within accredited DSME programs and have staff who are healthcare professionals experienced in the clinical setting. Most AADE DPP staff are either RDs, RNs or CDEs. No matter their educational or professional background, AADE requires all AADE DPP site staff to attend a DPP Lifestyle Coach Training from a CDC approved training entity (AADE itself is one). All AADE DPP network programs are also required to obtain CDC Recognition through the CDC Diabetes Prevention Recognition Program (DPRP). In addition to these requirements, AADE mandates that program coordinators must be a diabetes educator. A diabetes educator who oversees the DPP is very valuable to the success of the program and an appropriate role for a diabetes educator to play in this emerging field. And with Medicare coverage of DPP beginning in 2018, AADE DPP programs are ideally situated to become Medicare DPP Suppliers.

As a professional membership organization, AADE provides education,

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National Diabetes Prevention Program in the Panhandle

by Tabi Prochazka
Regional NDPP Coordinator
Panhandle Public Health District

Overview

Panhandle Public Health District (PPHD) is committed to reducing the burden of type 2 diabetes and other chronic diseases. PPHD, located in Western Nebraska, serves 12 counties with a population of about 90,000 residents covering over 14,000 square miles. These communities are classified as either rural or frontier with some areas being declared as food deserts. The current rate of adults in PPHD's jurisdiction with diabetes is 6.8, compared to 8.3 nationally.

The goal of National Diabetes Prevention Program (NDPP) in the Panhandle is to reduce the number of Nebraska Panhandle residents who develop type 2 diabetes and other chronic illnesses through three primary objectives:

1. Work with partner organizations with the capacity and infrastructure in place to recruit and train individuals to deliver the evidence-based lifestyle change intervention.
2. Identify strategies targeting people at risk for diabetes in order to raise awareness about risk factors and the availability of the lifestyle change program.
3. Facilitate relationships between partner organizations delivering the lifestyle change intervention and referring clinical partners; and develop a healthcare provider protocol that facilitates referrals into the program.

Program Development and Implementation

The initial steps of implementing the program involved planning internally and building support for NDPP. PPHD was then able to partner with organizations throughout the Panhandle so that each community in the district would have classes available. Organizations were chosen for partnership based on a shared interest in and commitment to reducing the burden of type 2 diabetes. A group of key partners and representatives from organizations were convened to develop a framework for the delivery of NDPP in the Panhandle.

The role of PPHD is to coordinate all the activities related to NDPP in the Panhandle and to serve as the hub for all data. PPHD continues to work cooperatively with all the partner organizations to ensure efficient operations and to collaborate with partners and lifestyle coaches to address challenges and new opportunities.

PPHD staff and local lifestyle coaches meet with the physicians at each of the hospitals and clinics in the Panhandle to foster relationships and increase physician referrals. Two forms are in use to facilitate physician referrals: 1) the Lifestyle Prevention Referral Form, used to refer prediabetic patients to the program, and 2) the HIPAA Release Form which, when signed by the participant, authorizes the lifestyle coach to request the participants past lab work results. PPHD is currently working with two clinics to analyze and assess current provider workflows for NDPP referrals and EHR capabilities for generating and receiving bi-directional feedback.

NDPP classes start when there is enough community or business interest to start a class. Classes starting in September and early October, or January and February show the most success. This allows the classes to be established prior to the holidays or to coincide with resolutions to improve health after the New Year. A coach does not have to wait for the first class to finish before starting another group.

Key Linkages

Hospitals and clinics were an ideal fit for referrals and sustainability. Eighty-eight percent of Panhandle hospitals have committed to sustaining the program in their communities by including NDPP in their Community Health Benefit Plans.

Dan Newhoff, wellness coordinator at Box Butte General Hospital, is a strong proponent. "The National Diabetes Prevention Program is one of the best programs that we could offer our employees, patients and community as a whole. Not only does this program help prevent type 2 diabetes, it is a slow progressing program that allows individuals to develop a sustainable means of health improvement. In addition to preventing disease, individuals learn to make dietary changes, physical activity, and behavior modification a lifestyle, rather than a fad."

In an effort to increase access and reduce barriers, NDPP in the Panhandle partnered with the Panhandle Worksite

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Diabetes Prevention in the Rural Counties

by Christine Blanke, RN, MS, CPH - Community Education Coordinator, Public Health Nurse with Four Corners Health Department, serving Butler, Polk, Seward, and York Counties

Across the nation, medical providers and patients have seen the value of the Diabetes Prevention Program. The program has improved the lives of patients nationwide. Fifty-eight percent of patients with pre-diabetes have gotten off the path to being diagnosed with diabetes or, at the least, significantly delayed the onset.

Four Corners Health Department also has seen the value of this program across its District of Butler, Polk, Seward and York Counties. Locally, we have seen these successes in a total of 70 participants:

- Total pounds lost: 1054.2 (average of 15.06 per person)
- Total physical activity minutes: 13,534.4 (average of 193.3 minutes per person per week).

Through state funding support, Four Corners has provided for 15 people to be trained as Lifestyle Coaches with most of these being within hospital and clinic systems. These are the individuals that lead the year-long Diabetes Prevention Program class. The evidence-based program aims to help participants learn what stands in the way of them living healthier and to set new habits. Also, through the class all the participants are guided to:

- Lose 7 percent of their body weight (or 15 pounds if they weigh 200)
- Be active (such as brisk walking) 30 minutes a day, 5 days/week

Four Corners has a partnership with the five hospitals in our District to offer the Diabetes Prevention Program. Staff within the hospitals or their clinic has been trained to deliver the program. Four Corners serves as their support for gathering data from the classes, marketing, having needed materials and becoming a Diabetes Prevention Recognized Program. Besides the hospitals/clinics, a long-term care facility has committed their resources for a lifestyle coach to provide a class. Four Corners is actively working toward engaging more long-term care facilities in this effort, as well as other sites such as businesses.

Throughout communities, local health departments and medical facilities are working together to find those who are at risk. Community organizations and local health departments refer at risk individuals to their medical provider for follow-up. Staff at local health departments can help connect clients to a medical home if they don't have one.

When you have patients diagnosed with pre-diabetes, consider referring them to a Diabetes Prevention Program near their home. Four Corners has partners in each county that offer this program. This year-long class has helped many people get off the path to diabetes. For example, a gentleman in Butler County shares his success with the program:

On July 28, 2015, I had routine blood tests by my family physician. I was out of range on 8 of the tests including triglycerides, glucose, HDL, and LDL, and was told I was on the verge of type 2 diabetes. I needed to change my diet and lifestyle.

In September I was made aware of the National Diabetes Prevention Program that was available at the Butler County Wellness Center. I enrolled with two goals in mind, losing weight and being more active. I was made aware of the excessive amount of fat in my diet and had immediate results in losing weight.

On December 1, my physician repeated the blood tests and found I was now within range on all the blood tests except two and had decreased my triglyceride level by 152 points and lost 21 pounds.

I am now looking forward to continued classroom support to help maintain the goals I made in September.

For helpful resources that equip medical providers and their team to better address this issue, visit www.PreventDiabetesSTAT.org.

To learn more about the Diabetes Prevention Program in Four Corners, please call Four Corners Health Department at (877) 337-3573, or send an email to info@fourcorners.ne.gov. □

National Diabetes Prevention Program: Efforts are in place to implement a sustainable lifestyle change program in Nebraska

by Sharon Leners, RN, BSN
Chronic Disease and Prevention Nurse for Public Health Solutions District Health Department.

Due to the number of high risk individuals, the CDC has created an evidence-base National Diabetes Prevention Program (NDPP) to focus on identifying high risk patients and creating physician referrals to the NDPP program for early intervention. Currently six local health departments in the State of Nebraska are leading this federal grant initiative to implement and sustain this evidence-based prevention program in our communities to decrease chronic disease and improve health outcomes.

Public Health Solutions was chosen as one of six health departments to implement these CDC grant initiatives. Our health department serves Fillmore, Gage, Jefferson, Saline and Thayer counties with a total population of 54,277. Looking at the 1:3 ratio for prediabetes, our communities have the opportunity to prevent over 18,000 new cases of type 2 diabetes. Public Health Solutions has partnered with the Diabetes Training and Technical Center (DTTAC) to train 14 facilitators in our five districts. Currently Fillmore, Gage, Jefferson and Saline counties have NDPP programs up and running.

Thayer County will have a program as soon as a facilitator is trained. Saline County offers a Spanish speaking program due to the high ethnicity of the area.

Results from the NDPP program have been positive in several of our counties. Gage County has been a target area for this current grant and at this time has two programs running, one at the YMCA and the other being held at the Beatrice Community Hospital and Health Center. Data from one of the current classes shows six individuals in the class with a total weight loss of 127.9 pounds after the first 19 weeks of the class. The NDPP program is a research-based program showing that a yearlong structured lifestyle change intervention will reduce the incidence of diabetes by 58 percent among adults with prediabetes and 71 percent in those older than 60 years of age.

I would like to share a story of a man named Robert. Robert had been overweight, depressed, pre-diabetic and on oxygen for his COPD. He had been advised to work with an advance illness management program with the hospital when his nurse encouraged him to try the NDPP program. Robert started this program in February of 2016 and has a total weight loss of 90lbs. He states "I would highly recommend this program" and "I have learned to read food labels, keep track of food and exercise, stress reduction techniques and how to care for my body in a better way." Michael Havekost, MD, is his Advance Illness Management physician and he has noticed considerable changes in his health. Dr. Havekost states "Robert is energetic and bright, has taken control of his life and now has hope for the future." Robert's primary care provider, David Gloor, MD, has noted that Robert has been visiting the office much less due to feeling so much better with the weight loss and exercise. Dr. Gloor stated "Robert used to visit the office two to three times a month due to not feeling well, and now I have not seen him since April." Robert's primary care physician also shared that Robert's fasting glucose has decreased from 151 to 101. This is just one story of many successes the NDPP program has had.

As new programs develop there will always be values and challenges. I reached out to interview a few local physicians to get their current views of the NDPP program. Some values of the program were community involvement, more opportunities for healthy programs in the community, helping patients build confidence and allowing people to have companionship as they seek to improve their health. A few of the challenges are the costs associated with the program and not currently being covered by insurance or Medicare. Physicians also noted that they want to make sure the patient is being followed correctly and good communication is provided back to the physician. One physician said a challenge

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Type 2 Diabetes Mellitus (T2DM) in Children and Adolescents – An Epidemic of its Own

by Karla Lester, MD, FAAP
Medical Director
Children's Center for the Child & Community
Pediatrician, Children's HEROES Clinic

The challenges and complexities of diagnosing and managing Type 2 Diabetes Mellitus (T2DM) in children and adolescents highlights the intersection of the art and science of medicine. To fully develop a continuum of care for the prevention and treatment of T2DM underscores the parallel tangential momentum of population health's efforts to integrate clinical and public health efforts.

The epidemic of childhood obesity has caused a concomitant increase in the number of youth with insulin resistance, prediabetes and T2DM. It is estimated that up to 15 percent of adolescents may have prediabetes and/or diabetes.

The childhood obesity epidemic affects at least 1/3 of children, with disproportionate risk in children who are minority and live in poverty. It is an epidemic, not only of obesity, but of adiposity-related comorbidities. At least 6 percent of U.S. children are severely obese, meaning their BMI is 20 percent over the 95th percent BMI cutoff for obesity. Though we are seeing some plateau of childhood obesity rates overall and slight decreases in early childhood obesity evidenced by recent WIC data, disparities continue and are progressing in some populations. The prevalence of obesity related comorbidities continues to increase. Children who are burdened disproportionately with the obesity epidemic are the same minority groups (Native, Asian, African and Hispanic American) that are experiencing an increase in prevalence of obesity related comorbidities including type 2 diabetes mellitus (T2DM). T2DM represented 6 percent of the diabetes in non-Hispanic whites, 33 percent in African American, 40 percent in Asian or Pacific Islander and 76 percent in Native American Youth.

Youth onset type 2 diabetes mellitus was previously referred to as non-insulin dependent diabetes. T2DM results from insulin resistance with an insulin secretory defect. T2DM in children may be insidious or asymptomatic in presentation. Children and adolescents with T2DM may present with an incidental finding such as glycosuria or hyperglycemia when presenting with another chief complaint, such as UTI or vaginal candidiasis. Patients can present more acutely with the typical symptoms of polyuria, polydipsia, weight loss and fatigue or with urgent presentations such as hyperosmolar coma. Complications associated with diabetes include increased risk of cardiovascular disease, end-stage renal disease, blindness and vascular insufficiency of the lower extremities. The incidence of complications increases with duration of illness and inadequate control.

Prediabetes refers to the conditions in which blood glucose levels are higher than normal but are not high enough for a diagnosis of diabetes. Prediabetes applies to the stages previously known as impaired glucose tolerance and impaired fasting glucose. Individuals with prediabetes are at increased risk for developing T2DM, cardiovascular disease and stroke. Data from adult and adolescent studies show that prediabetes in those with elevated BMI significantly increases the risk of development of T2DM, but is reversible. Data from the Diabetes Prevention Program Research Group study showing delay or prevention of onset of T2DM in adults points to the importance of early detection of prediabetes in childhood.

Clinical screening for at-risk populations includes taking into account multiple factors, not only obesity, that factor into diabetes risk. Genetic and environmental risk factors such as female gender, sedentary behavior and family history of T2DM should be considered. Prenatal nutrition and intrauterine environment also affect risk; low and high birth weight and gestational diabetes or T2DM are the greatest risk factors. Ethnic minorities are at higher risk and children with higher visceral or abdominal fat stores are at higher risk for insulin resistance and progression to diabetes.

Type 2 Diabetes Screening in Pediatric Patients

(Adapted from the 2007 Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity):

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Type 2 Diabetes Mellitus (T2DM) *(continued)*

BMI CRITERIA FOR SCREENING

- All children or adolescents who are severely obese (BMI >99th percent)
- Children or adolescents at the earlier age of 10 or onset of puberty with
  - Obesity (BMI >95th percent)
  - Overweight (BMI 85th-<95th percent) with one or more additional risk factors

RISK FACTORS

- Family history of T2DM in first or second degree relative
- High-risk ethnicity (African American, Latino, Native American, Asian American or Pacific Islander)
- Signs of insulin resistance or conditions associated with insulin resistance (hypertension, dyslipidemia, PCOS, acanthosis nigricans or small for gestational age at birth)
- Maternal history of diabetes or gestational diabetes during the child's gestation, low or high birth weight
- Patients prescribed SGAPs (second generation antipsychotics)

AGE AT INITIAL TESTING

- 10 years or onset of puberty if puberty occurs at a younger age
- Under age 10, or prepubertal if child has BMI > 99th percent or has one or more additional risk factors

RETESTING

- Biannually if normal, more frequently for abnormal values, rapid increases in weight, development of other comorbidities (hypertension or dyslipidemia) and/or onset of puberty

Summary of Criteria for Diagnosing Prediabetes and Diabetes:

	Prediabetes	*Diabetes*
Fasting plasma glucose	*100-125 mg/dL*	*>126 mg/dL*
2-hour plasma glucose (OGTT)	*140-199 mg/dL*	*>200 mg/dL*
Random plasma glucose	*>200*	*mg/dL*
Hemoglobin A1c	*5.7-6.4*	*>6.5%*

Source: Data from American Diabetes Association. Diagnosis and classification of diabetes mellitus. *Diabetes Care*. 2013 Jan;36 (suppl 1):S67-S74.

Identification and early treatment of T2DM may prevent complications and can serve as a motivator for some families to improve health behaviors. Referral to a pediatric endocrinologist is warranted if treatment is not feasible in the child's medical home or if the case is complicated.

Studies demonstrate that intensive glucose control decreases the risk for the development of severe complications. The cornerstone of treatment is the implementation of a healthy lifestyle with diet and exercise to promote weight loss. A multidisciplinary team approach with expertise in the treatment of diabetes is the best management for these patients. Children who are not responsive to diet and exercise or present with severe hyperglycemia require pharmacotherapy. Metformin is the only oral antidiabetic drug approved by the FDA for the treatment of pediatric T2DM. Metformin decreases glucose production by the liver and increases insulin sensitivity in the peripheral tissues. The TODAY study, the first long-term study of children with T2DM, has reported faster progression of T2DM and beta-cell failure in children, compared to adults and poorer treatment results. This suggests that a majority of youth with T2DM may eventually require combination treatment or insulin therapy.

Physicians are on the front lines to perform the assessment for risk factors and screening for prediabetes and T2DM, but, most importantly, often have relationships built with families, which allow a start to the conversation about diabetes risk.

A strategic goal for community physicians should be to influence and increase the family's understanding of health and encourage whole family change in key areas where there is strong evidence, such as: limiting sugar sweetened beverages; encouraging portion control using MyPlate and increasing family mealtimes; limiting sedentary screen time to no more than two hours per day; and increasing physical activity to at least one hour per day. Working from an early age and talking about health, you can steer the conversation away from the "o" word and talk about risk for diabetes or early heart disease.

Identifying risk factors, screening as evidenced for prediabetes and a focus on preventative measures from an early age are key to preventing or delaying the development of T2DM in those who are at risk. Just as with obesity treatment, the focus should be on engaging families. The success of a child depends on the family as well as the community supports that are in place.

We know that we live in communities where the healthy choice isn't the easy

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Type 2 Diabetes: Prevention is the Best Treatment

by Sarah Konigsberg, MD
Diabetes and Endocrine Associates
Lincoln

Preventing diabetes is worthy of our attention because of both the high cost and harmful health effects of established diabetes. The high price tag of health care is a topic of recent national concern, and much of this cost is due to diabetes. A staggering number of adults in the United States have Type 2 diabetes, approximately 12-14 percent of the population.[1] Caring for such a large number of people with diabetes is expensive. Incurred medical expense for adults with diabetes is more than twice that for individuals without diabetes. In the United States alone, total spending attributable to diabetes in 2012 was $245 billion, up from $174 billion in 2007.[2] The majority of this expense is shouldered by U.S. taxpayers through government-sponsored insurance. This figure comes from not only direct costs of diabetes, such as paying for medications, hospitalizations, and office visits, but also the indirect costs to society due to absenteeism, decreased productivity and a decreased life expectancy. Much of the money spent on diabetes is due to micro and macrovascular complications both increasing direct medical expense but also leading to disability and fewer years worked. The prevention of vascular complications is one solution that could lower costs, but it turns out this is often easier said than done.

Important diabetes trials in the 1980s to early 2000s informed us that tight blood sugar control, blood pressure control, particularly using ACE inhibitors and ARBs, statin use and a focus on smoking cessation can prevent diabetes micro and macrovascular complications. As a result, patients with diabetes are living longer, healthier lives. From 1990 to 2010, the rate of myocardial infarction in patients with diabetes decreased 67.8 percent. During that same time period, in those with diabetes, development of end stage renal disease was down 28.3 percent and amputation was 51.4 percent less likely.[3] Despite these improvements, a significant percentage of patients with diabetes still develop complications. At least partly this is explained by the high numbers, approximately 43 percent, of patients with diabetes who have a hemoglobin A1C greater than 7 percent.[4] Similar percentages are seen when looking at percent of patients with diabetes with blood pressure above goal and percent who do not take statins. While these numbers of patients meeting their targets are improved compared to 20 years ago, they are still disappointingly low.

Unfortunately, knowing how to prevent vascular disease due to diabetes is not enough. There are a number of barriers to meeting blood sugar goals that providers encounter. Two of the most difficult to overcome are convincing patients that managing diabetes is worthy of their time and is a good use of their money. Patients are asked to make significant lifestyle changes for a largely asymptomatic disease. The high cost of diabetes supplies and medications has become more of an obstacle in recent years as patients cover more of these expenses due to increasing deductibles and copays. One of the biggest challenges providers face is convincing patients to make their diabetes a higher priority.

Managing established diabetes is both costly and challenging. Despite improvements over the last two decades, diabetes remains a major cause of disability and decreased life expectancy. As with many diseases, the prevention of diabetes is our best option. We are fortunate to now have high quality, evidence-based diabetes prevention programs available in Nebraska. I encourage all providers who encounter patients at high risk to develop diabetes to refer to these programs. □

1) Menke A, Casagrande S, Geiss L, Cowie CC. Prevalence and Trends in Diabetes Among Adults in the United States, 1988-2012. JAMA. 2015; 314(10): 1021-1029.

2) American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2012. Diabetes Care. 2013 March.

3) Gregg E, Li Y, Wang J, et al. Changes in Diabetes-Related Complications in the United States, 1990-2010. N Engl J Med 2014; 370:1514-1523.

4) Casagrande S, Fradkin J, Saydah S, Rust K, Cowie C. Prevalence of Meeting A1C, Blood Pressure and LDL Goals Among People With Diabetes, 1988-2010. Diabetes Care. 2013; 36(8): 2271-2279.

Nebraska Program Success Stories

"When I found out that Cabela's was starting a program on diabetes, I was very interested. I was diagnosed with gestational diabetes in my second pregnancy with my son, Carson, which increased my, and my son's, chances of being diagnosed with type 2 diabetes in our future if not taken care of. I wanted to be able to learn how to prevent my family and myself from type 2 and joined the program. After the first two months I learned that I was pregnant again with my daughter, Madison. I decided to continue the class despite not being able participate in the weight loss part of the program. I continued to change my diet and do what I could for activity minutes. At 28 weeks I was again diagnosed with gestational diabetes. I had to track my sugars and take my diet to the next level. I was never insulin dependent. I had my daughter on August 29, and she passed her sugar test with flying colors. At eight weeks post-partum I retested my glucose and passed. My body has adjusted back and I was, thankfully, not diagnosed with type 2 diabetes. I plan to keep and increase my daily activity, while experimenting with my diet to see what works. This class gave me the tools to succeed. I would enjoy taking the class again to learn more and participate to my fullest ability."

Paula participated in the first National Diabetes Prevention program in Oshkosh in 2013. She had great success and was able to lose over 50 pounds! Paula has been able to maintain her weight loss by continuing to participate in classes and programs. Currently, Paula is participating in a class at her worksite because of the great support the program offers.

"My husband made the decision last January to sign up for the National Diabetes Prevention Program. I decided to join him even though I was skeptical since I am past 50, love to cook and eat and dislike exercise. My A1C was 6.2, my fasting sugar was 117 mg/dl, and I was miserable. Then the program began and I downloaded the smart phone app and logged what I ate every day. It was like a game to stay within my allotted fat grams and calorie limit. It was encouraging to watch the scale go down one to two pounds a week and it wasn't tough to accomplish. I'm still not good at exercise, but one year later I am 37 pounds lighter, my fasting blood sugar is 99, and A1C is 6.0. I have had the support of a wonderful coach and teacher and I am grateful for her. Taking this class has truly been life changing and a blessing for me this last year."

"I am happy to report I've reached my weight goal and my glucose stay around 100-120. At my three month check up with my doctor, she said my hemoglobin test was 5.1 and she was very pleased. She saw no need to prescribe medication and asked me to check in again in six months. I plan to stay 'on program' because I do not want to develop diabetes!"

Diabetes Prevention—Early Intervention in Prediabetes, a New Frontier of Opportunity *(continued)*

currently pay for the program, CMS will begin covering the program costs in January 2018, and efforts are underway to lobby all insurers to provide coverage in the future. Program prerequisites state that services must: 1) be supplied by CDC registered NDPP providers (CDEs with lifestyle coach training, follow the CDC curriculum, and achieve reportable "meaningful use"), and 2) be provided over a one year period (first six months at least 16 sessions over 16-24 weeks, second six months at least monthly meetings, allow opportunities for direct interaction between coach and participants, emphasize behavior modification/stress management/peer support). The ultimate goal is to achieve a 5-7 percent weight loss and establish a pattern of 150 minutes of exercise per week.

Who is eligible to participate in the NDPP? Those who are at a ***very high risk level***, placing them at 30-40 percent risk of developing diabetes within 10 years:

- Participant must be at least 18 years old
- Overweight BMI > 24, > 22 if Asian
- Hemoglobin A1C = 5.7-6.4 percent or FBS 100-125 or 2 hour GTT 140-199 (75 gram glucose load)
- Prior diagnosis of gestational diabetes
- No previous diagnosis of diabetes

Patients at ***high risk*** (FBS >100 but <126) have ~ 20 percent 10 year risk. Those at ***moderate risk*** level have two or more other risk factors (central obesity, hypertension, family history of diabetes, or age 45 or older) have ~ a 10 year risk of 10-20 percent. These groups should address their issues and counseling on how to decrease their risk of progression to higher levels of risk. Those at ***low risk*** with 0-1 risk factors have less than a 10 percent risk but still could benefit by addressing issues affecting their lifestyle, dietary intake and socioeconomic factors.

In summary the NDPP truly fulfills the triple-aim goals. ***Better care:*** Adherence to evidence-based guidelines, community and/or virtual-access based improved patient's satisfaction. ***Better outcomes:*** Lower incidence of diabetes, improved blood pressure and lipid profiles, less need of antihypertensive and lipid medications, reduced incidence of microvascular outcomes in women. ***Lower-cost:*** Cost savings attributed to decreased medication use, treatment of complications.

As physicians we owe it to our patients to champion and utilize this strategy to prevent diabetes--tell your fellow physicians and medical community, educate and engage your patients and support/lobby for coverage for the NDPP programs across the state. [2] □

1) AMA cost calculator to calculate potential 3 year netsavings:https://ama-roi-calculator.appspot.com

2) For more information on the NDPP program and screening tools:
(a) AMA: preventdiabetesstat.org
(b) CDC: cdc.gov/diabetes/prevention
(c) National Diabetes Education Program: ndep.nih.gov/am-i-at-risk/

National Diabetes Prevention Program: Efforts are in place to implement a sustainable lifestyle change program in Nebraska. *(continued)*

may be the need to have medication adjusted due to weight loss and worried the patient might not follow up routinely.

PHS is currently working with local physicians in Gage County to improve the referral process to the NDPP program and to look at how to identify these high-risk patients through the electronic health record. The CDC has a toolkit called "Preventing Type 2 Diabetes" that may be used as a guide to implement the NDPP program into your current clinic workflow. As medicine moves toward the fee for value model this is one prevention program to improve chronic disease health outcomes. □

American Association of Diabetes Educator's Model for the National Diabetes Prevention Program *(continued)*

guidance, advocacy and support to our members and those who work with people who have diabetes. More than 80 percent of our 14,000 AADE members and nationally certified DSME programs have reported working with people with prediabetes for many years, but most are not reimbursed for this work. Reports also continue to demonstrate a lack in enrollment of much needed DSME services for people with type 2 diabetes. These are gaps AADE continues to address. Through our work with the CDC as well as our collaboration with other national organizations regarding DPP, AADEs experience in implementation and support of DSME programs that are also DPP providers has flourished. We have seen it serve as a much needed additional tool to assist with the sustainability of DSME programs.

Since 2012, AADE has been tracking the AADE DPP model, which has been shown to be extremely successful in achieving standards as set by the CDC in a cost effective manner- similar to any other large, in-person network. AADE recently released a manuscript in The Diabetes Educator programs titled: *Achievement of Weight Loss and Other Requirements of the Diabetes Prevention and Recognition Program: A National Diabetes Prevention Program Network Based on Nationally Certified Diabetes Self-Management Education Programs.* This manuscript discusses the model and demonstrates results with the initial programs. To date, the CDC reports that AADE DPP sites are, on average, seeing a 6 percent weight loss for participants, exceeding the CDC requirement of 5 percent weight loss from baseline. AADE DPP sites also receive guidance and support, tools and resources from AADE staff. AADE has unanimous support from its leadership to continue working in prevention as well as increase services surrounding trainings, workshops, education, consulting, technical assistance and support, in order to expand the AADE DPP model within the DSME network and with diabetes educators. □

Type 2 Diabetes Mellitus (T2DM) *(continued)*

choice. We have a long way to go from a public health perspective to make sure that all children and families have access to healthy and affordable foods, that there are safe physical activity opportunities for every child and strategies for parents to address copious screen time opportunities. After all, when the dust settles and the comorbidity has been worked up and a treatment plan is settled on, each of us falls into the "need to eat healthy and move more" bucket. □

Resources:

American Diabetes Association - www.diabetes.org

Nemours - *kidshealth.org*

AAP Institute for Healthy Childhood Weight - *ihcw.aap.org*

choosemyplate.gov

www.childrensomaha.org/main/weight-management---heroes-program.

Children's Hospital & Medical Center HEROES (Healthy Eating with Resources, Options and Everyday Strategies) pediatric weight management program is the only multi-disciplinary obesity treatment program in the region designed specifically for the pediatric population. The program combines medical management, nutrition, behavior modification, fitness and behavioral health therapy to provide immediate and long-term management of childhood obesity to help prevent a lifetime of health complications for these children.

References:

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Ask a Lawyer

Does the mandatory duty to report under Nebraska's Uniform Credentialing Act apply if a chemically impaired practitioner enters the Nebraska Licensee Assistance Program?

The mandatory duty to report concerning an impaired professional applies if the first-hand knowledge is about an impaired professional in one's own profession or another profession. As a general rule, a credential holder, such as a physician or physician assistant, is obligated to submit a report to the Nebraska Department of Health and Human Services if he or she has first-hand knowledge that someone in his or her profession has been practicing while that individual's "ability to practice is impaired by alcohol, controlled substances, mind altering substances, or physical, mental, or emotional disability . . . ." Neb.Rev.Stat. § 38-1,125(1)(a). The mandatory duty to report also applies if the credentialed person has first-hand knowledge about a credentialed person in another credentialed profession practicing when impaired by "alcohol, controlled substances, mind altering substances, or physical, mental, or emotional disability." Neb.Rev.Stat. § 38-1,125(1)(b).

The report is to be submitted within 30 days of the occurrence that "triggers" the mandatory duty to report. In the legal world, "first-hand" information generally means a person actually witnessed, observed, or perceived through one's senses the conduct at issue.

These two duties within the mandatory reporting law, to report an impaired professional in one's own profession and an impaired professional in another profession, can be satisfied in a way that provides the reporting person and a chemically impaired professional an opportunity to avoid involving the Department's disciplinary process.

When the duty to report an impaired professional in one's own profession or in another profession is triggered, the requirement to file a report does not apply when the "credential holder who is chemically impaired enters the Licensee Assistance Program, ..." Neb.Rev.Stat. § 38-1,125(2)(c). This is the case except as otherwise provided in the Licensee Assistance Program's authorizing statute, Section 38-175.

The Department contracts with Best Care Employee Assistance Program to provide the Nebraska Licensee Assistance Program (NE LAP) services. By statute, the NE LAP services are limited to "providing education, referral assistance, and monitoring of compliance with treatment for abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering substance." Neb.Rev.Stat. § 38-175(1). Participation in NE LAP is voluntary.

Although participating in the program does not preclude an investigation concerning a credential holder which might result in disciplinary action, inquiries requesting information or assistance of the Department for a referral or treatment personally or for any other credentialed person for an alcohol or substance abuse problem must be referred to the NE LAP by the Department. This is the case unless a complaint is made to the Department about the credentialed person, has already been made about that person, or an investigation or disciplinary action is in process against the individual. Neb.Rev.Stat. § 38-175(5).

There are, of course, additional mandatory reporting duty requirements. These reporting duties arise whenever a credentialed professional is personally subject to the loss of employment, the loss or denial of privileges or the loss of a credential related to a "physical, mental, or chemical impairment." Neb.Rev.Stat. § 38-1,125(1)(c)(i), (ii), (iv), and (vi). In those situations, the mandatory duty to report is not excused by a chemically impaired credential holder's participation in the NE LAP.

Consequently, if the disciplinary process has not begun, if a complaint about a credential holder's impairment has not been submitted to the Department, or if the credential holder has not yet suffered an adverse action or consequence because of a chemical impairment, contacting the NE LAP may help a credential holder address his or her chemical impairment problem without the necessity of involving the Department and its disciplinary process.

(continued on Page 19)

Physicians Prone to Medical Liability Claims

NEJM Study Shows 1 percent of Physicians Accounted for One-Third of All Paid Claims

By COPIC's Patient Safety and Risk Management Department

A Jan. 2016 *New England Journal of Medicine* article[1] highlighted a study that analyzed paid medical liability claims—an indemnity payment made to an injured party and the physician's name was reported to the National Practitioner Data Bank (NPDB)—to determine if the characteristics of claim-prone physicians could be identified.

David M. Studdert L.L.B., Sc.D, of Stanford University and his colleagues analyzed 66,426 claims in the NPDB that were paid in the U.S. from 2005 through 2014. Investigators calculated the cumulative distribution of paid claims in two physician populations: doctors with one or more paid claims and all active physicians.

Key Findings

The biggest predictor of all for claim-prone doctors was whether they'd had a prior claim. Of all paid claims, 82 percent involved male physicians. The specialists with the highest total number of paid claims (not necessarily the highest frequency per individual physician, as there are more physicians in certain specialties) were internists (15%), OB/GYNs (13%), general surgeons (12%), and family physicians (11%).

Approximately 1 percent of all physicians accounted for 32 percent of paid claims. Among those with paid claims, 84 percent had only one paid claim during the study period (68% of all paid claims), 16 percent had at least two (32% of the claims), and 4 percent had at least three (12% of the claims).

The most important implications of these findings is that "frequent flyers are a significant problem, and identifying and remediating them early may help improve the quality of the healthcare system," said Dr. Studdert. "It suggests that there is some underlying factor that is predisposing certain physicians to malpractice claims. Provision of substandard care is the obvious culprit. Poor communication skills are likely to be another factor in this mix."

Study Limitations

When looking at this study, there are several things to consider:

- Not all malpractice settlements reach the NPBD; some physicians may be shielded from claims being reported individually in their name to the NPDB by their institutions or delivery systems.
- The authors used a simple head count. We know that there are physicians who practice longer hours and have a higher risk patient mix. This may make them more likely to be involved in litigation.
- There may have been self censoring. A physician may have backed away from tough cases, retired, or lost his/her license.
- Not all paid claims have merit. Certainly a paid claim is more likely to have substandard care, but there are many reasons a physician might settle a claim and not all are because of poor or indefensible care.

Increased Risk of Reoccurrence of Claims

Specialty had a marked impact on the risk of future paid claims. Neurosurgeons, orthopedic surgeons, general surgeons, plastic surgeons, and OB/GYNs had approximately twice the risk for an additional paid claim compared with internal medicine physicians. Psychiatrists and pediatricians had the lowest risks of recurrence. "In general, the high-risk specialties tend to be the ones that involve invasive procedures, where risk of adverse outcomes is higher, irrespective of whether the care was appropriate or negligent," said Dr. Studdert.

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There is also the issue of malpractice stress. Physicians may experience a significant psychological response to being sued, making litigation a high-risk time for another suit. A plethora of emotions may occur when you are being sued—fear, anger, rage, and shame are common. Some physicians do not tell their spouses of their lawsuit, and maladaptive behaviors might occur such as poor sleep, drinking too much, or self medicating. Poorly coping physicians appear to be off their "game" and may not follow their usual and customary decision-making processes.

Certainly, some of the risk may come from poor cognitive and knowledge

(continued on Page 19)

National Diabetes Prevention Program in the Panhandle *(continued)*

Wellness Council to provide NDPP classes onsite for member companies. PPHD facilitates the contracts between businesses and the partner organization that will be conducting the sessions. This has been a strong partnership thus far and a great opportunity for employers to promote employee health and wellness.

Outcomes

NDPP in the Panhandle has shown great progress since 2012. Participants are reducing their risk for diabetes and other chronic illnesses. Participant success stories indicate that the program affects not only their health but the health of their families and coworkers.

Interest in NDPP has grown largely through word of mouth. Several communities have established waiting lists to keep up with demand. Since the launch of NDPP in the Panhandle in 2012 and June 30, 2016, PPHD has partnered with area organization to coordinate 60 community classes and 21 business classes, with 827 participants losing over 4,600 pounds.

Sustainability

In an effort to make the Panhandle healthier place to live, learn, work and play, PPHD and community partners are committed to the sustainability of the National Diabetes Prevention Program. Support for the program has always been shared with partners and is becoming embedded in communities and worksite wellness programs. The program coordinator continues to build relationships and support for the program, provide support for the lifestyle coaches and provide evaluation of the ongoing classes to hold the program to the CDC's Standards for Recognition.

Sustainability is a key consideration when choosing new partners. PPHD provides training, coordination, supplies, technical assistance to implement the program with fidelity and an annual contract to help cover some of the costs of holding the classes. The contracted amount does not cover all of the costs, so the partner organization's mission must have an aspect of community outreach/education. This mission, coupled with the success of the program, lends itself to sustainability.

For more information contact Tabi Prochazka at tprochazka@pphd.org or visit www.pphd.org/DPP.html. □

Ask a Lawyer *(continued)*

NE LAP may be contacted at (402) 354-8055 or (800) 851-2336, or via email at lapne@bestcareeap.org. Confidential information should not be sent by email. NE LAP has 24-hour assistance available any day of the year by its professional counselors. If contact to the program is needed urgently, a call to (800) 851-2336 or (402) 354-8055 will put that person in touch with a professional counselor at NE LAP. The program may also be contacted during regular business hours, from 8 a.m. to 4:30 p.m. Monday through Friday. □

Ask a Lawyer is a feature of the Nebraska Medicine. If you have a legal question of general interest, please write the Nebraska Medical Association. Answers to submitted questions are provided by the Nebraska Medical Association's legal counsel, Cline Williams Wright Johnson & Oldfather, L.L.P., 1900 U.S. Bank Building, 233 S. 13th St., Suite 1900, Lincoln, NE 68508–2095. The answer in this issue was provided by Jill Jensen of the Cline Williams Law Firm. Questions relating to specific, detailed, and factual situations should continue to be referred to your own counsel.

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Physicians Prone to Medical Liability Claims *(continued)*

skills in a cognitive specialty or poor procedural skills if you're a surgeon or interventionalist. In addition, communication is a major component of litigation. Significant literature has shown that poor communication often leads to more litigation.

What to Do About the Findings of This Study?

In the study, the researchers are clear that they have identified risk factors for repeated litigation. "This problem of physicians who accumulate multiple claims and continue to practice...is a significant policy problem and one that we need to address," said Dr. Studdert. The authors of the paper call for further investigation into predicting which doctors are at risk and then implementing interventions such as training and supervision to improve their quality of care. □

1 *N Engl J Med 2016; 374:354-362*

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Retire? To do WHAT?

by Joe Bantz, CFP, AIF
Provided by the Foster Group

Ahh . . . retirement – that golden ring that you work 20, 30, 40 years to grasp. That elusive, mysterious goal masked in uncertainty. As an advisor, I have that discussion hundreds of times every year, looking at the financial dimension of retirement, helping strategize how to answer the, "Do I have enough?" question.

Yet, I've found the conversations taking a different direction lately. More and more clients, particularly physicians, are asking, "What's next?" Many are thinking about retirement as an opportunity to re-define themselves – focusing more on making an impact than making an income. The added benefit is that many of these options also produce an income.

I got to spend time with a client last week that perfectly illustrates this idea. After serving admirably in his profession for over 30 years, he decided to trade his editor's pen for a handyman's apron; he and his wife now rent out two mountain properties on their land, meeting interesting people from around the world. He provides the "general contracting" on the maintenance, upkeep, and improvements, while hiring their adult children to do the cleaning and extra labor. From a financial perspective, the income has been sufficient to keep him from tapping into his retirement funds, allowing them more time to grow.

Perhaps we are on the verge of a new retirement standard. For physicians, that might be working part-time, mentoring younger protégés, or serving the medically under-served population. When financial independence (or "financial freedom") has been achieved, the need to generate income no longer has to be a primary driver. Imagine working on your own terms – maybe two days a week, 4-6 hours/day, with no call. Or every Tuesday and Wednesday each week … unless you are out of town on vacation. You may find such joy and satisfaction that you'll never want to stop!!

Here are some suggestions to begin this thought process:

1) ***What is something you do that you enjoy so much that you forget to eat?*** My dad loved to work on projects. In fact, in the weeks before he and mom would visit, my wife would make up a lengthy to-do list for him (usually consisting of projects I had avoided since the last visit!) so that he would have enough to keep busy, which in turn kept him happy!
2) ***What did you love to do as a child but no longer have time for?*** When I was a boy, I would spend hours being a sports announcer – often "calling" my own baseball games as I played with a tennis ball against our barn door. Perhaps I should consider volunteering at the local high school when I stop working at Foster Group, or maybe see if the I-Cubs need a new play-by-play announcer!
3) ***If you knew you would die in 12 months, what would you want to be remembered for?*** While it's cliché to say you never know when you die, it's also true. Tim McGraw wrote a song about this – "Live Like You Were Dying" – but it's primarily self-focused. Most of us want to leave a legacy of sorts, so thinking about how you want to be remembered is a great way to determine what is most important to you.

Redefining retirement starts by thinking about retirement differently. Remember, it's possible that you could be retired longer than you actually worked! So, make those years count for something. Ask your financial advisor about this the next time you get together, and begin today to make the ideal retirement possible for you!

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VECTOR: SMALL CHANGES MAKE A BIG DIFFERENCE

Three Key Questions When Reviewing Your Disability Insurance

MATT ABELS, CFP®
Lead Advisor

1) IS MY GROUP DISABILITY COVERAGE ENOUGH?

a. A comprehensive analysis would be needed to say for sure, but often a group disability plan will not provide adequate income replacement in the event of an extended disability. Key areas to review, aside from the monthly benefit, would be the "own-occupation" period, benefit duration and the definition of disability. Individual polices tend to have more lenient provisions in these categories.

2) HOW OFTEN SHOULD I REVIEW MY DISABILITY INSURANCE COVERAGE?

a. At minimum, every few years and at key life changes. These include things like marriage, children, and increases in income and/or lifestyle.

3) SHOULD I BUY LIFE INSURANCE OR DISABILITY INSURANCE FIRST?

a. This one is tricky because you likely need both, but if you were to look at the probabilities, you are more likely to be disabled than to die prematurely.

A comprehensive review is the place to start; this should give you a few basic things to consider.

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