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Summer Breaks Help Prevent Burnout — Especially Among Physicians

It’s summertime, and you need a break! The U.S. has a culture of working too hard, and physicians are some of the worst offenders. Don’t let Labor Day pass without spending at least one afternoon at the beach.

We can joke about it, but there’s rising concern about burnout and depression among physicians. One study of 7,000 residents found that 50 percent showed depressive symptoms and 8.1 percent reported suicidal thoughts over a 12-month period.

“Physicians are given enormous workloads, make near-impossible life-and-death decisions regularly, and are expected to be alert and ready to go constantly. It’s unsustainable,” says Dr. Adam Perrin, a professor of family medicine and director of student wellness at UConn Health. “To enjoy life, you need balance and a break.”

Working too much can lead to burnout, or at the very least, a lack of enthusiasm. And that can be bad news not only for doctors, but for patients.

Studies show that depression and burnout make doctors significantly less likely to read about the next day’s cases, and up to five times more likely to make errors when prescribing medication.

Many doctors work too much because they don’t want to ‘abandon’ their patients. But taking care of yourself is taking care of your patients, too — even when the worst happens. Telling a dying patient that you have a vacation coming up, you regret the timing, and you wanted to tell them how much you care before you leave is very respectful, Perrin says.

And while vacations are essential, your recovery and rest shouldn’t center on them. Rest and self-reflection should be a regular pursuit. For example, Perrin sings in a community choir.

“I’ve made many friends, we sing gorgeous music, and it fills the soul,” Perrin says. However you choose to take a break this summer, we hope it does the same for you.
UConn Health

1,200 square-foot hybrid operating room with advanced imaging (coming soon), plus 10 spacious ORs

A New Era at UConn Health

During the early morning hours of May 13, 300 UConn Health doctors, nurses, staff, leaders, and volunteers mobilized to begin the carefully planned move of 70 inpatients, one by one, to UConn John Dempsey Hospital’s new patient care tower.

The new tower, which along with the original hospital building comprises the hospital, was designed with the latest, most advanced technology and patient safety, comfort, and privacy at the forefront. The aesthetic is made to be peaceful and healing, with soothing colors, earth-toned wood and tile, noise reduction features, and tons of natural light thanks to floor-to-ceiling windows throughout.

The tower is the biggest project of Bioscience Connecticut, the initiative launched by Gov. Dannel Malloy in 2011 to make Connecticut a leader in bioscience research and create new jobs. In addition to staff jobs at UConn Health, the project created more than 5,000 construction jobs.

“I am extremely impressed,” said patient Dr. Michael P. Kruger, who had 30 inpatients on the patient care floor when the tower opened. “I think, in how you recover and what the outcome’s going to be,” he said.

Not to mention the state-of-the-art technology in the 11-floor, over 381,000-square-foot “hospital of the future.”

The Operating Suite is home to the da Vinci robot and the Mazor Robotics Renaissance Guidance System, the only one of its kind in New England for robotic-guided spine surgery. The suite includes 10 operating rooms, each with LED boom lighting, special rubber floors and air filtration systems for infection control, high-definition Black Diamond Video systems for enhanced surgical vision, live-broadcasting for medical education and physician training, and real-time communication with the Department of Pathology.

A 1,200-square-foot hybrid operating room will open this fall, equipped with advanced imaging capabilities for minimally invasive and complex procedures.

Four high-tech smart robots called TUGS will deliver pharmacy medications to nursing units across the hospital, along with high-speed, wall-based tube systems. Other safety measures include a centralized monitoring system, allowing patients to be observed remotely 24 hours a day by technicians, in addition to traditional bedside monitoring by their nurses. And those nurses will be able to reach patients even faster if anything happens, thanks to Rauland Responder bedside call systems.

“The technology that we are now able to use for our patients is going to enhance the care that we deliver,” said Anne Sakitis, nurse manager of the orthopaedic surgery floor. “We are great at what we do, but we are going to do it even better in the new tower.”

The tower has six inpatient floors dedicated to intensive care, intermediate care, medicine, oncology, orthopaedic surgery, and general surgery, and 169 private patient rooms, including 28 in the intensive care unit. Each room honors one of Connecticut’s towns with a scenic nature photograph taken in that town by a local photographer, and features a view of the Farmington Valley, a high-tech bed and monitoring equipment, a private bathroom, and a couch that turns into a bed for visitors.

The hospital now has 24/7 visiting hours. The Emergency Department includes 169 private rooms, including 28 in the intensive care unit. Each room honors one of Connecticut’s towns with a scenic nature photograph taken in that town by a local photographer, and features a view of the Farmington Valley, a high-tech bed and monitoring equipment, a private bathroom, and a couch that turns into a bed for visitors.

The tower represents a new era at UConn Health and for health care in our state. The opening of the new hospital tower is a very special generational milestone,” said UConn John Dempsey Hospital CEO Anne Diamond. “We did it! We dreamed it, we built it, and now we’ve opened it.”

We are great at what we do, but we are going to do it even better in the new tower.

— Anne Sakitis, nurse manager of the orthopaedic surgery floor

Top: A UConn Health nurse shows a patient how to adjust her bed in a room on the sixth floor of the new tower, which is dedicated to oncology.

Bottom: Dr. David McFadden, surgeon-in-chief, gives direction in one of 10 new operating rooms. The room is equipped with a Black Diamond video camera, near top left, which allows surgeons to view a close-up video of procedures.

Opposite Page: A view of the new, 11-story patient care tower shows the glass exterior and floor-to-ceiling windows throughout.

Dr. Peter C. Albertsen received the 2016 Eugene Fuller Triennial Prostate Award from the American Urological Association (AUA) for his contributions to the understanding of prostate cancer, most notably in epidemiology and statistical analysis.

Read more: bit.ly/albertsen

Dr. Bruce Gould was named medical director of the Transforming Clinical Practices Initiative (TCPI) of The Community Health Center Association of Connecticut, Inc. (CHC ACT).

Read more: bit.ly/brucegould (Continued on page 4)
UConn Health Works to Reduce Complications, Costs in Common Procedures

Just seven procedures account for most of the costs and complications of emergency surgeries in the U.S. each year, according to a study in The Journal of the American Medical Association April 27.

UConn Health’s surgeon-in-chief Dr. David McFadden is not surprised. These seven procedures are some of the most common, including gallbladder and appendix removal, and it makes sense that the most common surgeries are also responsible for most of the costs. And since UConn Health is on a constant quest to provide the best care possible, the surgery department was already working on some of the issues discussed in the study.

For example, UConn Health participates in the National Surgical Quality Improvement Project (NSQIP), a service that tracks surgical complications such as infections, strokes and heart attacks, and alerts the surgeons to patterns. Catheter-associated urinary tract infections are one such common complication that happens in hospitals across the country. UConn Health surgeons decided that they would no longer accept that.

“We have started a focused, all-out war on catheter-associated urinary tract infections,” says Dr. Stephen Lahey, chief of the Department of Cardiothoracic Surgery and vice chair of the Department of Surgery. The NSQIP data has shown that there are subsets of patients who are much more likely to get urinary tract infections. The surgery department now focuses on these patients and has significantly reduced this type of infection. Reducing post-operative pneumonia in vulnerable populations is the department’s next project, Lahey says.

UConn Health’s work in this area is part of a national focus on improved population health care that stems from the passage of the Affordable Care Act, commonly known as Obamacare. Medicare has begun listing surgical complications that should happen rarely or never, and will lower or deny reimbursement to hospitals where they commonly occur. Private insurers are following suit. This can be a potent incentive for hospitals to support what medical personnel want to do anyway: find and reduce or eliminate the sources of complications.

“While lowering or denying reimbursement for certain patient events such as hospital readmission is a powerful incentive for hospitals to minimize their occurrence, we must never lose sight of the primary reason we do this — providing the best and most appropriate care to our patients,” Lahey says. “The main goal, he says, is “to alleviate suffering and improve the health of the population we serve. If we do that well, the finances will take care of themselves.”

LAB NOTES

Latest UConn Health Discoveries

RESEARCHERS REVEAL A SECRET OF SEPSIS

Severe bacterial infections can push the human body into sepsis, a life-threatening cascade of inflammation and cell death that can be difficult to cure. In the May 19 issue of Cell, immunologist Vijay Rathinam and colleagues at UConn Health proposed an explanation for how bacteria trigger such a dangerous reaction: The human cells aren’t really being invaded. They just think they are, at least when sepsis is caused by gram-negative bacteria. Gram-negative bacteria secrete vesicles of lipopolysaccharide (LPS) that can prompt the bacteria to emit more LPS, spilling inflammatory cytokines that slip past its defenses and self-destruct, says Rathinam. The vesicles of lipopolysaccharides (LPS) that can be secreted by gram-negative bacteria can prompt the bacteria to emit more LPS, spilling inflammatory cytokines that slip past its defenses and self-destruct, says Rathinam. The vesicles of lipopolysaccharides (LPS) that can be secreted by gram-negative bacteria can prompt the bacteria to emit more LPS, spilling inflammatory cytokines that slip past its defenses and self-destruct, says Rathinam.

Get the full story at bit.ly/uconnsepsis

NANOPARTICLES: GUIDED MISSELS FOR DRUG DELIVERY

Powerful drugs such as chemotherapy and steroids can be devastatingly effective against their intended targets — but they have a tendency to devastate other, healthy body systems as well. UConn chemist Jessica Rouge is working to make these medications more discriminating in their action by bundling them into guided nanoparticles. Her lab is developing aptamers, molecules that bind to a specific target proteins or cell receptors, that can be attached to the nanoparticles to guide them straight to damaged or diseased cells. This approach could help cancer patients avoid the worst side effects of chemotherapy, it could also be useful for asthmatics who need steroid anti-inflammatory drugs. With this strategy, the drug could be sent straight to the lungs, side-stepping side effects completely.

Get the full story at bit.ly/uconnnano

WALNUTS MAY IMPROVE YOUR COLON HEALTH

Eating walnuts may change gut bacteria in a way that suppresses colon cancer. A team of researchers from UConn Health and The Jackson Laboratory for Genomic Medicine found that mice that ate 7-10.5 percent of their total calories as walnuts (about an ounce per day for humans) developed fewer colon cancers. Walnuts are packed with compounds known to be important nutritionally, but it may be as a whole food that they pack the most significant anti-cancer punch against colon cancer, the most common cancer in the world. The research, supported in part by the California Walnut Commission and the American Institute for Cancer Research, was published May 23 in the journal Cancer Prevention Research. UConn Health Center for Molecular Medicine cancer researcher Dan Rosenberg and colleagues are now working on a long-term study in humans.

Get the full story at bit.ly/uconnwalnuts

CONGESTIVE HEART FAILURE PLUS TYPE 2 DIABETES WORSE THAN WE KNEW

Data from more than 5,300 patients with Type 2 diabetes has shown that these patients face a one-in-four chance of dying within 18 months of being hospitalized for congestive heart failure, according to the global EXAMINE study, led by UConn Health professor of medicine Dr. William B. White. Patients with Type 2 diabetes have two to three times the heart disease risk of the general population. White hopes the results inspire patients and doctors to focus more on preventing cardiovascular disease. The findings were presented June 11 at the American Diabetes Association’s (ADA) annual meeting in New Orleans and published online in the ADA journal Diabetes Care.

Get the full story at bit.ly/uconnEXAMINE
Finding Skin Cancer in a Flash

New technology at UConn Health has practically eliminated both unnecessary biopsies and human error in skin checks at the dermatologist’s office. UConn Health is the only institution in Connecticut to offer the latest smart technology to hunt for skin cancer and keep an eye on changing moles. The integrated body-scanning camera and smart software technology, called FotoFinder Bodystudio Automated Total Body Mapping, “helps us find skin cancer in a flash,” says Dr. Jane Grant-Kels, professor and vice chair of UConn Health’s Department of Dermatology and director of the UConn Cutaneous Pathology Center and Melanoma Program.

FotoFinder allows dermatologists or staff to take 20 or more photos of a patient’s entire body, including the palms and the soles of the feet, in about 10 minutes. It also allows easy comparison of photographs year after year, and alerts the dermatologist to changes or new growths. "This technology is going to help us save more lives from skin cancer and melanoma," says Grant-Kels. "It allows for early detection and a more exact science of monitoring patients’ skin changes.”

If concerning growths are detected, another recently arrived technology called In Vivo Reflectance Confocal Microscopy uses a non-invasive optical imaging technique that provides a high-resolution cellular image of the skin. This new technology is safe and painless, and in many cases can be used in lieu of a painful skin biopsy. "PhotoFinder coupled with Confocal will help us go a long way to reducing the number of biopsies performed, including unnecessary biopsies of non-cancerous skin growths," Grant-Kels says.

For baseline and follow-up photo sessions using the FotoFinder technology, a patient will be asked to get into the proper positions guided by a red laser light and a specially designed floor mat that ensures proper foot positioning.

“This technology is going to help us save more lives from skin cancer and melanoma.”

— Dr. Jane Grant-Kels, Vice Chair, UConn Health Department of Dermatology

UConn Health is the only institution in Connecticut to offer the latest smart skin-mapping technology.

Dr. Suzanne Rose was awarded the American Gastroenterological Association’s 2016 AGA Distinguished Educator Award.

Dr. Jane Grant-Kels, right, and Jody D’Antonio, CMA, center, examine a high-resolution, cellular image of a patient’s skin using a technology called In Vivo Reflectance Confocal Microscopy.

For baseline and follow-up photo sessions using the FotoFinder technology, a patient will be asked to get into the proper positions guided by a red laser light and a specially designed floor mat that ensures proper foot positioning.

“The technology also allows dermatologists to compare lesion or mole photos side-by-side and to quickly zoom from 20x up to 70x magnification to examine suspicious areas in high-resolution and determine which spots to examine more closely with the traditional handheld dermoscopy tool. The system also includes high-tech, handheld electronic dermoscopy with a built-in medicam for even closer examination and additional photo captures. Plus, the machine is mobile and can be moved easily among exam rooms.”

The card indicates where the patient is being treated and provides contact information for the UConn and Connecticut Children’s programs and blood banks so doctors can confirm proper next steps.

UConn Health, Partners Pilot Sickle Cell ID

UConn Health, Connecticut Children’s Medical Center, and the American Red Cross have created an identification card for individuals with sickle cell disease, to ensure patients in need are properly treated at any hospital they might visit.

The New England Sickle Cell Institute at UConn Health and the Hemoglobin Disorders Clinic at Connecticut Children’s treat a combined 500-600 patients with sickle cell disease, a group of inherited red blood cell disorders that involve oxygen-carrying hemoglobin turning from a normal round shape to a crescent, or sickle, shape. The sickle-shaped cells cause blockages that prevent the flow of oxygen in blood vessels and can be extremely painful.

According to David Rosinski, Director of Cardiovascular Perfusion at UConn Health, Connecticut Children’s, and the Heart Center of Greater Waterbury, when patients have to be seen at centers other than the ones where they are treated, they are often thought to be simply looking for pain medication.

Many hospitals decide to perform a quick transfusion on these patients, which can make it harder to properly treat the patient through apheresis later.

Sickle cell patients ideally receive blood during apheresis from like donors, Rosinski says. For example, African American sickle cell patients should, if possible, receive blood from African American donors, because there are certain antibodies present in the blood cells that are specific to their genetic profiles.

The card indicates where the patient is being treated and provides contact information for the UConn and Connecticut Children’s programs and blood banks so doctors can confirm proper next steps.

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The card indicates where the patient is being treated and provides contact information for the UConn and Connecticut Children’s programs and blood banks so doctors can confirm proper next steps.
Anthony Giansanti, 27, of Montville, Conn. has been playing baseball practically since he could walk. It’s in his blood. Giansanti’s grandfather and his nine brothers started their own league in Hartford in the 1950s. Giansanti first picked up a bat at age 4, and began playing competitively at 9.

“It’s always been a dream of mine to play professionally,” says Giansanti, who joined the Chicago Cubs organization shortly after graduating from Siena College in Loudonville, N.Y. But Giansanti, who has played on a variety of Cubs-affiliated minor league teams around the country and is now playing for the Bridgeport Bluefish in the independent Atlantic League, almost didn’t achieve his dream. During his freshman year at Siena, he was running to first base during a game against Tulane when he experienced what he says felt like a gunshot in his upper right leg.

The hamstring injury put Giansanti on the sidelines for two months. He did special pool exercises, underwent ultrasound and muscle-stimulation therapy, and rested every day. But no matter what he did, the injury continued to resurface throughout college and his early professional career, benching him for two to three weeks each time it flared up.

In 2015, Giansanti was running to third for the Triple-A Iowa Cubs when he felt the same warm, intense cramp as he had his freshman year at Siena. Again, he was out for two months.

On the recommendation of other athletes, Giansanti visited UConn Health’s Dr. Cory Edgar, who sees patients at UConn Health Storrs Center and is an orthopaedic team physician for UConn Athletics. Edgar and Dr. Matthew Hall, another Huskies team physician, diagnosed him with a hole in his hamstring, and suggested an advanced, injectable treatment called platelet-rich plasma (PRP), followed by physical therapy and rehabilitation.

For four months, Giansanti practiced eccentric strength training and stretching. He received two PRP injections, six weeks apart.

“I now have absolutely no issues with my hamstring,” says Giansanti. “I am faster and stronger than ever before.”

Treating Athletes and Average Folks

The UConn Health team of nine sports medicine doctors who are trusted with keeping professional athletes like Giansanti, as well as more than 700 UConn Huskies student-athletes, in the game are the same ones who see 26,000 everyday people each year. And they bring the same cutting-edge strategies to the table to prevent and treat injuries for both types of patients.

“UConn’s sports medicine experts apply what keeps their top-performance athlete patients healthy and translate that knowledge to help guide the care of their everyday recreational athlete patients, and the weekend warriors, to keep them moving and doing what they want to do as they age,” says Dr. Robert Arciero, chief of the Division of Sports Medicine at UConn Health, a UConn Athletics team physician, and past president of the American Orthopaedic Society for Sports Medicine.

The cooperation between UConn Health and UConn Athletics benefits both groups — and their patients.

“UConn Health sports medicine experts are phenomenal and an integral part of our UConn Athletics team, as we rely heavily on their expertise to care for...
can fix many common injuries, such as stress fractures or shoulder dislocations. UConn’s research is taking treatment a step further.

“Our mission is to provide all aspects of musculoskeletal medicine for patient care, while advancing basic science and research, teaching and training doctors, and educating researchers around the world,” says Dr. Augustus D. Mazzocca, chair of the Department of Orthopaedic Surgery, director of the UConn Musculoskeletal Institute, and an orthopaedic team physician.

Much of the work centers on using a patient’s own tissues, including PRP or stem cells, to help heal injuries. One particularly ambitious undertaking is the HEAL (Hartford Engineering A Limb) Project, a global initiative led by UConn Health’s Dr. Cato T. Laurencin that aims to regenerate a human knee within seven years and an entire human limb by 2030.

Edgar, who treated Anthony Giansanti with PRP injections, studies how stem cell injections aid healing in tendon, bone, and rotator cuff injuries, as well as meniscus transplants.

“Our use of a patient’s own stem cells can expedite tissue healing, reduce the risk of repeat surgery, and speed a patient’s return to daily life,” Edgar says.

And ensuring patients can get back to doing what they love — be it dancing in the kitchen with their spouses or playing on the court in front of thousands — is the primary goal.

Giving Patients New Hope

Mazzocca is using stem cells to treat a particularly tricky type of injury. Athletes and average Joes alike struggle with stubborn rotator cuff injuries, which can occur while playing sports or from overuse, but sometimes happen for unknown reasons. In addition to being common, torn rotator cuff tendons — which hold the shoulder in place and allow for its movement — don’t always heal, leaving patients unable to lift or move their arms, and doctors don’t always know why.

Mazzocca and his team are working on both physical therapy and biological methods to change that. “The patient with a bad outcome is the patient that drives us,” he says.

Part of Mazzocca’s team is conducting tests on cadavers to find out how much strain it takes for a newly repaired rotator cuff tendon to fail. The goal is to determine how much strength patients are likely to have post-surgery, giving doctors an idea of when they can tell patients to start rehab work.

Another group is testing different physical therapy regimens to see which ones help patients recover fastest and most completely.

Dr. Augustus D. Mazzocca
Driven to Make a Mark

When famed Boston Red Sox pitcher Curt Schilling needed surgery on his labrum, rotator cuff, and biceps tendon in 2008, his surgeon called UConn Health’s Dr. Augustus D. Mazzocca for back-up.

Mazzocca assisted with a biceps tendoless procedure he developed with Dr. Robert Arizer, chief of UConn Musculoskeletal Institute’s Division of Sports Medicine, in an attempt to save Schilling’s career. But Mazzocca approached operating on the 2001 World Series MVP like he does any patient.

“Our job is to make sure people get back to doing what they do as quickly as they can, whether they’re pitching for the Red Sox or working on a road crew,” says Mazzocca, director of the UConn Musculoskeletal Institute (MSI) and chair of the Department of Orthopaedic Surgery.

Mazzocca says he chose to specialize in shoulder injuries because when he became a doctor, there was less known about shoulders than about the other key joint in orthopaedics — the knee. “I felt that was an area where I could make a mark,” he says.

And he has. Mazzocca has three patents on devices and processes to improve rotator cuff repair healing, and has designed three devices used to reconstruct shoulder injuries. Rotator cuff injuries are common, painful, and stubborn — often failing to heal properly after surgery.

“We’ve made a little dent in it,” he says. “We try to keep going and going and trying to solve the problem. We still have a lot to learn. That’s probably what motivates us the most.”

Mazzocca has spoken in more than 12 countries and on five continents on the cell biology, biomechanics, and outcomes of shoulder and elbow surgery; is a member of the prestigious American Shoulder and Elbow Surgeons Society; and co-founded the New England Shoulder and Elbow Society.

“At the MSI, we really enjoy teaching what we’ve learned to as many people as we can. That’s among our biggest goals, whether it’s people from around the world or our own medical students and fellows,” Mazzocca says. “Our fabric is education, trying to bring everybody up to a higher level to be able to treat patients better.”

Bridgewater Bluefish outfielder Anthony Giansanti, 27, is back in the game after UConn Health sports medicine experts treated his recurring hamstring injury.
Working in the health care industry is no defense against insurance jargon, it seems. When Dr. Victor Villagra, director of policy at UConn’s Health Disparities Institute (HDI), recently posed the question at left to the audience at a health care industry conference luncheon, very few attendees answered correctly. And yet everyday people shopping for health insurance for their family or small business must routinely solve these types of questions to accurately compare plans — or risk making an expensive mistake. Many doctors are effectively small business owners and face these same complex calculations when choosing health insurance for their employees.

And doctors face a different, but related, dilemma on the other side of the equation, when a patient with a high deductible insurance plan suddenly cannot pay the full deductible amount. High deductible plans set the stage for an adversarial relationship between a doctor and patient, where the doctor feels compelled to hire a debt collector to get paid. The patient feels betrayed, and the caring relationship deteriorates beyond repair.

“New insurance designs are extremely complex. Patients don’t know how to use their insurance,” and often doctors get stuck in the middle, Villagra says.

Besides confusing calculations, health insurance is rife with obscure vocabulary. A Kaiser Family Foundation survey found that 58 percent of uninsured survey participants didn’t know what a “health insurance formulary” was — it’s the list of drugs covered by that insurance provider — and 9 percent of those surveyed thought it was “the form you send to your insurance company when you need to have a medical bill paid.” Additionally, many did not know what a “health insurance physician network” was — some believed it was a collection of computers doctors use to talk to each other.

Further, almost half the survey respondents could not pick out the correct definition of “deductible” on a multiple choice test.

Confused Yet?

Fighting for Equity

BY KIM KRIEGER

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Confused Yet?

Fighting for Equity

BY KIM KRIEGER

Robert receives a bill for $530.

The member rate charged by his in-network doctor to remove a wart from Robert’s foot in early January.

Robert has a $30 co-pay.

The amount paid at the time of the visit, which doesn’t count toward the deductible.

His plan includes a $100 deductible.

The out-of-pocket cost before insurance kicks in.

A 20 percent coinsurance applies to the visit.

Robert has to pay this much of any covered service.

Sorry! The correct answer was $210
HDI are aiming to change that, by increasing literacy and coverage available.

They believe raising health insurance literacy is the best, and most immediate, way to help people avoid bad insurance policies — and broken relationships with their doctors. The question is, how?

In the near term, Villagraga and his colleagues want to train “health insurance helpers” who can station themselves in libraries and community centers during open enrollment and help people shopping for health insurance make wise choices. These helpers will be especially important in poorer communities and areas where many people do not speak English well, do not own their own computers, and may find the health insurance descriptions impenetrable. The HDI also wants to persuade health insurance companies to make insurance easier to use by writing the plan descriptions and subscriber agreements in plain English rather than jargon.

But the HDI is primarily engaged in research and policy development. In order to change the system, the HDI is partnering with organizations directly involved in providing health insurance to consumers.

In order to change the system, the HDI is partnering with organizations directly involved in providing health insurance to consumers. For example, the HDI is working with Access Health CT to make a computer app that can help people more easily compare benefits between health plans. Access Health CT is the operator of Connecticut’s health insurance exchange. Small business owners and private citizens without health coverage currently use the exchange to figure out which plans and subsidies they qualify for under the ACA, or Obamacare. After a rough start in 2014, when the exchange website malfunctioned and shut out many would-be enrollees, Access Health CT has rallied. It’s now considered one of the most successful exchanges in the U.S. But Access Health CT still has a lot of challenges to deal with, both in getting people covered and then helping them use the insurance they — or state taxpayers — are paying for. A majority of people who enroll in a health care plan through Access Health CT are eligible for Medicaid, and one of those challenges occurs when they ‘price out’ and are no longer poor enough to qualify. For example, consider M., a carpenter living in central Connecticut who asked not to be identified. He had health insurance through his wife’s job as a certified nursing assistant until 2013, when her facility closed. M. lost his job six months later, and his family of four became eligible for Medicaid. They were able to enroll relatively easily by calling Access Health CT.

“My dentist didn’t take the insurance anymore, my dermatologist didn’t take it, but we made do,” M. says. The family switched dentists and worked a deal with the dermatologist. Their primary care doctors continued to accept their new insurance because they were existing patients. M. considers himself lucky.

But his income went up due to overtime this past year, and state law lowered the Medicaid income threshold for a family of four to just $37,665, down from $48,830 the year before. His wife called Access Health CT and spoke with someone about the family’s new situation. She was told they could purchase health insurance for somewhere in the range of $1,400-$1,800 a month.

“That’s a mortgage payment,” M. says. “I’d have to take on two more jobs.”

His wife is in nursing school now and he hopes they can get insurance through her new employer when she graduates. Until then, he hasn’t heard anything concrete about when they’ll lose their current coverage. For Access Health CT, helping people obtain coverage and cope with the financial realities of health insurance in Connecticut is just the start of its mission. Now, the exchange wants to move forward with helping people find doctors who will treat them, and getting them the right type of care, focused on prevention and wellness, according to CEO Jim Wadleigh. And that’s where the HDI and Access Health CT intersect. HDI can give Access Health CT policy support and research backing, and Access Health CT can actually implement it.

“They are the lever of change,” says Pat Baker about Access Health CT. Baker is president of the Connecticut Health Foundation. The organization granted the HDI $155,244 this year to increase health literacy in the state, and is glad to see them partnering with other agencies.

The Connecticut Health Foundation’s primary focus is increasing health equity in Connecticut, and Baker finds it particularly disturbing that half of African Americans and Latinos newly insured under the ACA in 2014 haven’t used their health insurance yet. Many of the non-users receive large subsidies. It’s an enormous transfer of wealth from taxpayers to private companies. Society isn’t doing that so citizens can stay sick or be turned away from doctors who “don’t take Obamacare,” Baker says.

Substantive change is needed, and in addition to Access Health CT and the Connecticut Health Foundation, the HDI is working with the Connecticut State Medical Society, the state Office of the Healthcare Advocate, ConnecticutCare, the Department of Social Services, and many local community groups. Over the long term, HDI policy director Villagraga has very specific goals. For example, he hopes the number of health plans available in marketplaces will be reduced, allowing consumers to choose from fewer, but better, options. This would also help reduce the Medicaid income threshold for larger populations. Another long-term goal would introduce performance-based regulation to make health insurance costs more transparent, similar to the rules that protect consumers from abuse by public utilities. And last but not least, Villagraga hopes high-deductible plans will be eliminated and turned into insurance that provides better value and stays out of the doctor-patient relationship.

“We are in the health insurance capital of the world,” Villagraga says, referring to Cigna and Aetna headquarters and many other insurance companies that have large presences in Connecticut. Villagraga used to work at Cigna, and he doesn’t intend to cast a shadow over the industry. “If it were simple and equitable, I could live with it,” he says. “But it’s not equitable.” Until it is, Villagraga and his partners at the HDI and institutions across the state will work for a better, fairer system of health insurance.
America’s Opioid Epidemic: What Doctors Need to Know

Q&A with Dr. Surita Rao, UConn Health assistant professor of psychiatry

What do the new Centers for Disease Control and Prevention guidelines call for?

In March the CDC called on primary care doctors to more carefully assess each individual patient’s risk of taking an opioid and to take extreme caution when prescribing it for longer than seven days for acute pain, unless for terminal cancer or palliative care. The lowest-effective dose of non-slow-release pain pills should always be used, and patient use needs to be continuously reevaluated. Guidelines stress the critical need for increased education and communication about opioid risks including constipation, drowsiness, stopping breathing, drug and alcohol interaction, addiction, overdose, and death.

What should medical providers keep top-of-mind?

For patients, physicians should always consider first NSAIDS (such as acetaminophen and ibuprofen), routine exercise, physical therapy, hot and cold compresses, and possibly steroidal injections. If opioids are necessary, beware that long-term opioid use can lead to physical dependence and intense withdrawal. Patients should be slowly weaned off. Patients who have developed an addiction to opioids that goes beyond a physical dependence will need to undergo medical detox, or take agonist maintenance medication to curb their brain-receptor cravings. Psychotherapy specifically targeted for substance abuse disorders, including individual counseling and group therapy, is always needed for successful recovery from an addictive illness. Patients should be encouraged to proactively lower their daily pain risk factors, not abuse or share opioids, and seek medical attention if they start to experience withdrawal symptoms or addiction.

Dr. Surita Rao is on the board of directors of the American Society of Addiction Medicine and past president of its Connecticut chapter.

Can you characterize the U.S. opioid epidemic?

Our country’s opioid epidemic has been going on for several years. The U.S. is the biggest global consumer of prescription opioids. In 1997, 76 million prescriptions were written, more than doubling by 2013 to 207 million. Americans consume nearly 100 percent of the world’s hydrocodone (Vicodin) and 81 percent of its oxycodone. The majority of those physically addicted or overdosing are getting opioid prescriptions from their doctors’ offices.

What are the dangers of opioids?

These strong pain pills are very physically addictive and it’s often hard for patients to live without them, even after their pain subsides. The biggest dangers of opioids are overdose and death. After doctors stop prescribing them, some patients turn to the street to illegally get their pills, while some may even switch to heroin. When mixed with heroin, anxiety medications, or alcohol, opioids are even more likely to lead to overdose.

UConn Health welcomes the following new providers:

**David Banach, MD, MPH**  
Specialty: Infectious Diseases  
Location: Farmington

**Deena Casiero, MD**  
Specialty: Sports Medicine  
Location: Farmington

**Victoria Cialfi, MHS, PA-C**  
Specialty: Dermatology  
Location: Canton, Farmington

**Kerry Cipriani, APRN-BC**  
Specialty: Cardiology, Electrophysiology  
Location: Farmington

**Keri Discepolo, DDS, MPH**  
Specialty: Pediatric Dentistry  
Location: West Hartford

**Yu Ming Victor Fang, MD**  
Specialties: Obstetrics and Gynecology, Maternal-Fetal Medicine  
Location: Farmington

**John Travis Hinson, MD**  
Specialty: Cardiology  
Location: Farmington (Dual appointment with The Jackson Laboratory for Genomic Medicine)

**Kerry Cipriani, APRN-BC**  
Specialty: Cardiology, Electrophysiology  
Location: Farmington

**Dawn Murphy, MD, MPH**  
Specialties: Geriatrics, Internal Medicine  
Location: Farmington

**Lyla Natt, APRN**  
Specialties: Family Medicine, Internal Medicine, Primary Care  
Location: West Hartford

**Andriy Palamar, CRNA**  
Specialty: Anesthesiology  
Location: Farmington

**Angela Planika, APRN**  
Specialty: Orthopaedics  
Location: Farmington

**Mary Samson, APRN**  
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Location: Farmington

**Dawn Murphy, MD, MPH**  
Specialties: Geriatrics, Internal Medicine  
Location: Farmington

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