Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, it's been just over a month now since Health Care Reform has passed and the administration is moving forward pretty aggressively to make sure the implementation plan goes forward and what some say is the biggest transformation of government since World War II. Margaret, I don't know what your thoughts are but when I hear that statement I am reminded of Daniel Moynihan "everyone is entitled to their own opinion but they are not entitled to their own facts", what's your opinion on this?

Margaret Flinter: Well, it's a yes or no answer. It is a radical transformation on some level because we are certainly trying to move towards universal coverage in access to Health Care in a way we haven't done before. You know maybe it's because we live in the world of Health Care everyday but I don't see this is a big transformation of government. Instead I think we are really building on a lot of infrastructure already in place and I think of it as making the country and health care better for the next generation of both consumers and providers.

Mark Masselli: That's the right attitude. Granted the law's main provision won't take affect into 2014 but a lot is happening right now to get the process going and on the right track. The states are working on their high-risk pools to make sure of people with serious preexisting conditions can get affordable coverage now and I imagine the insurance companies are very focused on this new reality that includes dealing with the elimination of preexisting conditions but also a huge new market pool that's coming their way. I am a little concerned about what's going to happen in the next two years in terms of an insurance premiums those insurance companies need to keep those premiums in check.

Margaret Flinter: Well, a little antidote to that worry is some welcome news. The White House made it official in an announcement on Monday that they are nominating Dr. Don Berwick to head the Centers of Medicare and Medicaid Services. We have talked about him earlier and his tremendous track record in patient safety and innovation. And we are going to be waiting patiently over the next several weeks as he goes through these senate hearings and hopefully towards confirmation. And another piece of good news the President has tapped a very highly respected senate staffer Peter Rouse to head up the implementation effort. They will be joining Nancy DeParle who has been convinced to stay on along with Secretary Sebelius from HHS that's a formadible team and they are going to need all the talent they can get.

Mark Masselli: They are, Peter Rouse that was a great choice. Senate credentials are impeccable Obama's chief of staff and then on with Tom Daschle as both the majority and minorities chief of staff when Daschle was in power. I want to stay on topic though about the new implementation and the new

departments that are being created. There is the new office of Consumer Information and Insurance Oversight. We hear from politico the Jon Kingsdale might be up for that appointment.

Margaret Flinter: That's another great pick. Now let's turn our attention to today's guest, we are going to speak with Dr. Danielle Ofri, an attending physician at Bellevue Hospital in New York City. She has written her new book Medicine in Translation: Journeys with My Patients. Her stories of her patients' lives both before they came to the US, their lives here and her experiences as a doctor caring for them are both memorable and they are very instructive as we grapple with the issue of how we are going to provide Health Care for immigrants many of whom won't qualify for insurance even under reform.

Mark Masselli: No matter what the story, you can hear all of our shows on our website at Chcradio. We also like to give a special shot out to WPRR 1680 AM in 95.3 Public Reality Radio in Grand Rapids, Michigan. They will be airing our shows starting this week on Friday at 5:00 p.m.

Mark Masselli: Hello Michigan, and as always, if you have feedback, email us at Chcradio.com, we would love to hear from you. Now, before we speak with Dr. Ofri, let's check in with our producer Loren Bonner for headline news.

Loren Bonner: I am Loren Bonner with this week's headline news. As a Department of Health and Human Services forges on with developing and implementing the major reforms that go into effect this year as well as in 2014, a new office of Consumer Information and Insurance Oversight will be there to help. The office will facilitate and administer the temporary high-risk pools set to be ready in June and states that choose to take part and it will establish and oversee new rules on Medical Loss Ratios and the state-based insurance exchanges that will take over in 2014. As HSS continues to refine certain regulations in the new law, we are also hearing about some more good news for college students and young adults, another group of Americans who will reap an immediate benefit of Health Care Reform. As it stands now the law requires insurers to offer coverage of dependents up to age 26 to stay on their parents' health plans starting in September. But HHS announced it with working with insurers to voluntarily provide coverage for graduating college seniors and young adults in advance of the September start date. Nancy-Ann DeParle Director of the White House Office of Health Reform welcomed to the news.

Nancy-Ann DeParle: Some companies may come forward on their own, the secretary has been working with them and has asked them to go ahead and keep some people on who might otherwise go off and I actually met with some companies today who said they might reach out and allow people to come on early.

Loren Bonner: In fact two of the largest health insurers United Health Group and WellPoint came forward on Monday with plans to allow college seniors to stay on their parents' health plans right after graduation this spring. The move is a good sign that insurance companies are moving quickly to comply with the new laws provisions, but with insurers plans will take effect June 01. Today we are exploring Immigration and Health Care and a large part of delivering quality care to a diverse group of people is being able to speak the same language as the patient. Joint Commission Accreditation requires that health care providers address effective communication, cultural competence and patient centered care. One useful service that accomplishes this goal that's also used here at the community health center is a translation service called Language Line. It connects the health care worker to a certified medical interpreter within seconds. I visited New York Hospital Queens that services one of the most diverse communities in New York to see how a Language Line works and why it's so important. I am here in the Pediatrics Emergency Room with Kendra Haydel, The Language Assistance Coordinator at New York Hospital Queens. She tells me that the Language Line Service is used most often here, because the emergency room is usually the first point of entry for the patient.

Kendra Haydel: This is sort of like our first line of providing language assistance so our first encounter starts here. Once they come through they are asked what is your preferred language and at that moment if they say anything other than English then that's where the chain of events take place where it's like okay, now we know we are going to treat a patient and that 11 they speak X, Y and Z and then language services are then put in place.

Loren Bonner: Several cordless telephones are within reach for doctors and nurses to take into a patient's room, the process is quick and easy.

All the staff has to do is push the talk button it's going to automatically dial to language line, and then now the second handset that they would give to the patient.

Yes operator.

I want to (inaudible 07:47) 7757.

Thank you.

Hi interpreter.

Hello.

Loren Bonner: Haydel tells me that about 40% of the hospitals in patients are what's considered LEPs, Limited English Proficient Patients, in other words the hospital relies on the service a lot. The hospital has been using language line in

the 170 languages and dialects it offers for almost 20 years now. Recently starting in 2007 the hospital began piloting a video interpreting service which provides translation in Spanish and English sign language as well as the hospitals most frequently used languages Spanish, Mandarin and Korean and soon to come Russian. I am impressed when Haydel shows me a pamphlet that staff members have on hand. It conveniently lets patients point to the dialect they speak.

Kendra Haydel: For example if patients can point here, or even if you know they come in and especially it's in emergency room area if you know they can't speak, if they are in too much pain at least they can point and say okay here this is speak publish and then this way we can get someone who is speaks certain language.

Loren Bonner: Donna Pegararo, a nurse on duty today in the PED, tells me that with Language Line there is never any second guessing what a patient is saying.

Donna Pegararo: We can get the story from beginning to end without missing anything in between from the parent through the Language Line through our translator. Upon discharge it's so much easier to clearly give the parents teaching instructions that they are going to need and as far as medications that they have to give or what to look out for.

Loren Bonner: And as we all know that's key for better patient outcomes and lower readmission rates. As Haydel puts it we make sure that when they are discharged they are discharged in good health. Let's listen out to our guest interview to get a more personal perspective on how health care workers deal with patients from a diverse set of backgrounds.

Mark Masselli: This is conversation on health care; today we are speaking with Dr. Danielle Ofri a physician at Bellevue Hospital in New York City, co-founder and editor-in-chief of the Bellevue Literary Review, and author of the new book Medicine in Translation: Journeys with My Patients, published by Beacon Press. Welcome Dr. Ofri.

Dr. Danielle Ofri: Thank you so much.

Mark Masselli: Your book underscores the complexity regarding immigrant rights to health care in our country a very relevant and important topic and when there continues to feed the debate over health care reform. You give us a very clear picture of this complexity with your story of one of your patients Julio Barquero, a 36-year old woman from Guatemala who has severe heart conditions and will die unless she receives a transplant. Can you tell us her story?

Dr. Danielle Ofri: Sure, I met Julio as a young woman in the early 30s when she presented to our hospital with severe congestive heart failure. It turned out she

had a genetic cardiac disease for which she would eventually die from and normally we cure this with a heart transplant. But she is undocumented and as such she can't be on the list for an organ transplant. I have now followed her for several years she is a wonderful woman who would otherwise be an excellent candidate otherwise healthy reliable smart but can't get this heart transplant and so one of the issues that when it first happened is no one had the guts to tell her. We all felt so horrible and so failed to telling her you know to a person that she can't get a heart transplant. It took us a long time to break the news and now we switched her over to a waiting game and one day she was going to fall and we would be able to help her.

Margaret Flinter: Dr. Ofri this is a compelling humanitarian argument I think you have just made it and a moral argument to be made for providing health care for undocumented immigrants but beyond that I think the public health community in particular would argue it's just short sighted for us not to provide health care since ultimately emergency treatment at least is always rendered and another argument is that the children have both documented and undocumented immigrants have born in the US automatically are citizens qualify for health care and thus it's just short sighted not to provide primary and preventive care of like prenatal care for instance. So we have practical, financial moral and emotional arguments being made. One of you can sort out for listeners the arguments we are likely to hear over the next year as the debate unfolds concerning immigrants rights to healthcare in this country and under health reform.

Dr. Danielle Ofri: Well I think that to some degree immigration is a bit of a red herring in the health care debate. I think that it plays well in terms of sound bytes and ads about people taking advantage of the system and we will solve everything if these weren't the problems. But this is really a side issue I think our health care systems has serious issues that need to be resolved whether or not immigrants are part of the picture. The fact that we have uninsured people American citizen seems like an unethical thing from a professional and medical standpoint. And so I think that it's an easy way to channel some of the anger and resentments toward the immigrants but you are right I think that there are compelling reasons and I can understand the philosophical debate that well if someone is illegal, here they shouldn't get an organ, I can even appreciate that. But the problem is what happens on a human level, what happens with doctors and nurses who take care of this young woman and have to tell her this and watch her die. We don't have anything in our medical saying that says _____ 13:12 how you tell someone that can't get the care that they would otherwise deserve. So it's very fraud and I think we haven't paid much attention to the basic humanitarian issues. In terms of cost you are right it is probably making much more sense to give everyone free primary care and avoid the costly complications later.

Mark Masselli: Every patient you describe in your book medicine and translation as an immigrant and they come from all corners of the globe. You deal with

language barriers, gaps and understanding of different cultures that trauma of previous lies on a daily basis and that's just one of this struggles you faced in treating such a diverse group of patients. What comes through in your book is just how much work you do to coordinate their care. Advocate for your patients get resources for them, work often not associated with physicians tell us about how you deal with the language and cultural barriers but also at this important juncture and health reform goes forward who else do you have on your team that helps you with all these important non medical challenges?

Dr. Danielle Ofri: Well I think that highlights the predicament of all the primary care doctors, general internists, pediatricians who are sort of the first step for people in health care system we do a lot of coordinating a lot of non medical work even places that are better staffed than where I work even it still requires a lot of work from a doctor that is not reimbursed and that's hard to imagine for example a lawyer putting all this time and not doing by the minute for the extra phone calls and forms. But that seems to be part of the deal for medicine I think we haven't recognized that it's impossible to provide good care in 15 minutes and do all these things that are required. I mean good care isn't just medicines. All the other parts that come together and making sure that patient has the right home services that they get their prescriptions refilled, they can understand their medications. So a lot of us look pretty even medical home where there is a team who will be helping a patients care. And there is a social worker, we have coordinate services, and maybe a pharmacist who can go over the medications and nurse who can coordinate, nurse at the screening, I think someone estimated once that for doctor to do all the right screening and primary care intervention would take an 8-hour visit, so it's not even though it's demanded it's not possible.

Margaret Flinter: Dr. Ofri when you decided to take that year off in Costa Rica which sounded wonderful you took your husband and two young children with you and you gave birth to your third child while you were there. Now we have often heard that Costa Rica has a very good primary care system in particular, what were your observations on the health system there as compared to the United States, how did you view the experience of being the foreigner if you will in another country and their health system and any of us since learned that you brought back to your work ability?

Dr. Danielle Ofri: Well I had a wonderful experience having a child in Costa Rica on all fronts. And the medical care was excellent, I had just wonderful, I feel very safe and cared towards, but I also found the entire society and this includes the medical staff is just much calmer and slower, but there is also oriented towards children the way that I didn't see here. The amount of help people gave me on the street in the community I was walking to a store someone would hold your child while you shop, at the bank, they would bring you to the front of the line if you had a baby with you, so I felt the health care was excellent. Some of the things that I learned though was when you don't speak the primary language

even if you have education and resources it's still going to be challenging. For example making an appointment over the phone and it's like the language is very hard and you don't have body language and things to pull you with. I really struggled to make my appointment and even though my doctors spoke English the nurses didn't do that, administrators didn't so I realized how difficult it could be even with the resources that I have brought to it and look at my patients who are much sicker or maybe have fewer resources, how challenging and how many are there, are just may get lost just getting to the hospital.

Mark Masselli: Today we are speaking with Dr. Danielle Ofri a physician at Bellevue Hospital, New York City and author of Medicine in Translation: Journeys with My Patients. There is one patient whom you treated at the end of her life, Mrs. Lang, after her death you found that she decided to stay in United States when she was diagnosed with cancer because she thought she would receive better care here than she would if she returned to China. Can you tell us her story and what did it reveal to you?

Dr. Danielle Ofri: Well her story as I learned later that she came to America on a vacation to see her siblings leaving her young son and husband behind for just a few weeks. And then became sick while she was here. So she decided to stay in America because she felt she would get better care. She ended up spending 5 years in America and was never able to see her family again, her family wasn't able to come and in the end her family, their most certain wish for her that she wanted was to have her body sent back to China to go home. So she was only reunited with her son and husband in death and they brought her body home to her family for burial.

Margaret Flinter: Powerful stories in your book and I would like to ask you about one more of them, your patient Dr. Chan who decides to do the opposite almost, leave his elderly wife who is in mid-stage of Alzheimer's disease here and he would return to his homeland of China to spend his last years and it raises the issues of the elderly which are such a concern to all of us and while the Health Reform Legislation we have just passed includes much more support for the elderly. I think we still have to ask the question how well prepared is our country to meet the health care needs of the elderly and what are you doing at Bellevue in this area that you think is innovative around supporting health care for the elderly.

Dr. Danielle Ofri: It is a real issue. The elderly would be the fastest growing segment of the population certainly the ones with the most medical need and this particular couple was a sweet elderly couple who I, they live in my neighborhood so they would have kind of keep pads on them. And in fact I wrote about them just because they were an interesting couple before he announced he was going back to China so it was quite a shock that he decided he needs for his health to be in China where he felt more supported and he felt he didn't have a support here. I think it's very important for a lot of elderly, isolated may not have a family

support, or they can't be there round the clock. And it's quite and arduous experience in that, okay the healthcare system for someone who is frail and elderly who may or may not speak English to fill up forms to navigate phone trees, it's very, very sick as many people get lost by the wayside. I think the _____ 19:27 geriatric is expanding for that. And again having some kind of medical team where there are social workers and visiting nurses, because I think people can really get can walk between the tracks.

Mark Masselli: And Dr. Ofri you wrote about the importance of knowing and understanding someone's back story. You take care of patients from NYU's Survivors of Torture Clinic, caring for these patients requires such sensitivity how were you trained to care for these unique patients?

Dr. Danille Ofri: I think there is no training that you can get from a book for this and I think that comes to all of the parts of medicines and dealing with other cultures, dealing with patients who are smelly, distasteful, angry, who have come from backgrounds that they were very abused. I think all these are things you have learned on the job and I think from watching your senior physicians, your leaders walking the walk more than talking the talk, and demonstrating humanitarianism and professionalism is how the students learn how to be the doctor they want to be.

Margaret Flinter: Dr. Ofri speaking of students you practice at a teaching center and are training the next generation that's part of Bellevue's mission. Medical schools and other health professional schools are increasingly seeing the power in narratives, writing the patient's story as a valuable tool to using and understanding the patient's experience instead of just recording the objective data and we do this in our organization with our Nurse Practitioner Residency Training Program as well. Columbia University has even set up a whole program in training health professionals to write narratives. As a writer yourself, how do you think this might contribute to improving both the quality of care and also satisfaction for patients and providers.

Dr. Danielle Ofri: I think there is an enormous contribution for the students that I supervise. They always have to hand in the write-ups for the patients and I ask them to do one of them just in the narrative, just to tell the patient's story and it's amazing how often it's clinically relevant. One short example, I had a student interview a young woman with asthma and she and her boyfriend had a dog and she knew the dog worsened her asthma but she didn't want to get rid of the dog because her boyfriend would be crushed, so then this student interviewed the boyfriend for another point of view, he said, oh we should get rid of the dog but she would be crushed. So she got them to guess and they really thought they could actually give the dog to a friend and her asthma got better so by going into the story of the experience of the illness not only is it interesting, it helped us know the patients more. There are valuable clinical and therapeutic insights.

Mark Masselli: Dr. Ofri when you look around the country in the world what do you see that excites you in terms of innovations and should our listeners of conversations be keeping an eye on?

Dr. Danielle Ofri: I think it's the upcoming students and interns. Despite what everyone says on medicine, even the way it used to be I look at these incoming students, interns and residents, and there is still full of idealism. They are in medicine for the right reason. There is no medicine to make money or get prestige because there is easier places to get money and prestige and I feel as though my own idealism is you know four to five each new group coming for this. I would say keep an eye on the young people, the classes are incredibly diverse now, there is a majority of women in many medical schools, many-many more minorities from different backgrounds, people from nontraditional backgrounds coming in later, serving humanities and these are the doctors who are going to I think be the leaders.

Margaret Flinter: Great. Today, we have been speaking with Dr. Danielle Ofri, a physician at Bellevue Hospital in New York City, and author of the new book Medicine in Translation: Journeys with My Patients. Thank you so much for being with us Dr. Ofri.

Dr. Danielle Ofri: Thank you. My pleasure.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives.

Margaret Flinter: This week's bright idea focuses on a new discovery that's helping patients who suffer from Parkinson's disease to stay healthy and cope with pain and it might teach us all a few things. Parkinson's disease is a degenerative disorder of the central nervous system that's both chronic and progressive. So it persists and worsens over time. Even in the less severe earlier stages Parkinson's can seriously disrupt everyday activities leaving patients unable to walk or talk. Over a million Americans suffer from Parkinson's and 50,000 new cases are diagnosed each year. Although some treatments do exist to lessen the severity of the symptoms none have succeeded in completely halting the disease's progression. About several months ago Dr. Bastian Bloom of the Netherlands began exploring a new treatment that not only is helping to ease patient's physical and psychological pain in real time but may also change the direction of Parkinson's research and treatment in the future. During an exam, one of Dr. Bloom's patients informed him that although he was virtually unable to walk he regularly rode his bicycle around the neighborhood for miles at a time. After seeing his patient bicycling in person Dr. Bloom began testing his other patients and he saw the same results over and over. On the bike, the symptom, these patients rode with ease and agility but as soon as they dismounted symptoms returned immediately. Dr. Bloom's research is still in the beginning stages. He has only been experimenting with cycling therapy for a few

months but the research has the potential to affect significant change in the understanding and patient experience of Parkinson's. Dr. Bloom and his colleagues hypothesized that Parkinson's patients are able to cycle because bicycling uses a completely different part of the brain that is not as compromised by the disease. They know that hypothesis is the rhythmic nature of cycling helps the nervous system to allow the continuous motion. Further exploration into these areas may lead to a more complex understanding of the disease, how to best treat it but also how to live well with it. Research prospects aside, cycling allows Parkinson's patients to experience a sense of freedom and normalcy that their condition frequently denies them. The experience this psychologic relief while getting valuable exercise. Research is still in its initial stages but it's already making a difference for individual patients and it has the potential to help others. Now that's a bright idea.

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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