Mark Masselli: This is Conversations on Healthcare. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret the number of covered Americans continues to increase even after the close of the open enrollment in April. More than 7.2 million Americans are newly covered under Medicaid expense including those earning up to a 138% of poverty line.

Margaret Flinter: And it should be noted Mark that, that number includes the newly covered American to eleven states that did not expand Medicaid. There are tens of thousands of newly covered Texans under Medicaid who had been uninsured heard all the talk about the healthcare law sought information about their options only to find out there were already eligible under the existing Medicaid guidelines and we have seen a lot of that right here in our own backyard.

Mark Masselli: And it also should be noted that the federal government is covering up to 100% of the Medicaid expansion for three years. States that choose not to expand Medicaid have left billions of dollars on the table that would have helped them ensure more of their residence about 25 states thus far refusing to participate.

Margaret Flinter: And I am still waiting to see what happens after the mid-term elections on that because healthcare has become a truly partisan agenda and people's health and well-being is hanging in the balance. GOP analyst are now trying to promote the party's image as the party of yes. The new strategy is going to focus on changing the law and I think we will see a lot more on this new approach as we get closer to those elections.

Mark Masselli: And there is another story that continues to unfold the Ebola epidemic in West Africa which has spread to several countries. The World Health Organization is issuing strict warnings about travels to that region. They fear the epidemic is months from being brought fully under control.

Margaret Flinter: And American aid workers who have fallen ill have been given an experimental drug that had not been tried on humans. Until now some promising results and so the question is how much the manufacture of this drug containing and treating this deadly virus continuing to pose just an enormously serious global health challenge.

Mark Masselli: And that's something our guest today knows quite a bit about. Dr. Deane Marchbein is President of the US Chapter of Doctors Without Borders. They have clinicians on their ground in West Africa, in Gaza, Afghanistan in numerous hotspots around the world.

Margaret Flinter: And we will also hear from Lori Robertson the managing editor of FactCheck.org.

Mark Masselli: But no matter what the topic you can hear all of our shows by going to chcradio.com and as always if you have comments please email us at info@chcradio.com or find us on Facebook or Twitter because we'd love hearing from you.

Margaret Flinter: Now we will get to our interview with Dr. Marchbein in just a moment.

Mark Masselli: But first here is our producer Marianne O'Hare with this week's headline news.

Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. There is a drug development boom underway. One of the upsides of the deadly outbreak of the Ebola virus instead of West African nations. Well the World Health Organization warns the epidemic should be considered a global concern. Drug manufacturers who have been working on experimental treatments are fast-tracking their efforts. Well two American healthcare workers have shown improvement after being given an experimental treatment. The FDA is approving its limited use in this current crisis and the federal government is providing funds for these drugs to be rapidly developed cautioning that Ebola could be used in a terrorist attack.

The computer engineer said to be the fix-it man for the troubled federal health exchange website healthcare.gov, Google computer engineer Mikey Dickerson has been tapped to run a newly created US digital service a government agency created by the White House to fix any other troubled governmental websites with the same private sector wizard (inaudible 03:39) applied to the fix of the belligerent federal exchange. The goal is to lower smart technologist from the private sector and bring them in-house. Meanwhile healthcare.gov continues to be evaluated and tweet as they ready for the next open enrollment which happens in November.

Newly installed Secretary of Veterans Affairs Robert McDonalds vowed at a recent gathering of disabled veterans that he would restore credibility and trust to the VA with a series of actions. McDonald highlighted plans to conduct an independent audit of all VA scheduling practices and penalize VA outpost performing poorly. He acknowledged a long tradition at the agency of cover-ups, attempts to game the system and a failure to protect whistle blowers and said that all that is going to change. I am Marianne O'Hare with these healthcare headlines.

Mark Masselli: We are speaking today with Dr. Deane Marchbein President of the Board of Directors at Doctors without Borders winner of the 1999 Noble Peace Price an International Organization dedicated to offering healthcare and medical training in war

torn and impoverish countries around the world. Dr. Marchbein is a anesthesiologist practicing at Mass General Hospital in Boston. She earned her MD at the University of Pittsburg and completed residency at Mass General and the Boston Children's Hospital. Dr. Marchbein welcome to Conversations on Healthcare.

Dr. Deane Marchbein: Thank you very much.

Mark Masselli: You know doctors without borders was formed 40 years ago in 1971 in the context of the crisis it would be offering and you joined the organization in 2006 taking over leadership of the US chapter in 2012. And during that time there's been no end to the world conflicts, doctors without boards finds itself in. I think people know about doctors without borders in the abstract but what's the core mission of doctors without borders and who are you serving around the world?

Dr. Deane Marchbein: So you're right doctors without borders was founded 40 years ago as a result of a very difficult Civil War in Biafra and Nigeria and the premise was that we thought there needed to be an organization that could both deliver direct emergency medical care but also speak out about the underlying causes and what we were seeing. So the primary mission is as I said direct delivery of medical care and emergency aid to people affected by arm conflict, epidemics, malnutrition, natural disaster and also situations where people are excluded to access from healthcare. And we're currently operating between 60 and 70 countries worldwide, so we have more than 30,000 people who are working for us and about 10% of those are our international staff. And then we work very closely with locally acquired staff in the places where we work and they really are the backbone of the work that we do and those people as the international staff are doctors they are nurses, they are logistics experts and even mental health workers (inaudible 6:50) an important mental health component of most of the projects that we do.

Margaret Flinter: Well Dr. Marchbein we are watching humanitarian and war zone crisis just unfold before eyes it seems almost every day your members are on the ground in West Africa where the Ebola outbreak has led to hundreds of deaths and seems to be spreading and I know has affected healthcare workers on the ground conflict in Ukraine, the ongoing Syrian crisis. So maybe you could share with us a little bit about in these hotspots what are your healthcare workers experiencing there and how do they grapple with delivering both the emergency medical care but also you are delivering almost some primary care in an emergency environment I would think.

Dr. David Marchbein: So all of these are really very diverse context and one of the issues in Syria is that Syria had been a country where people had access to a very high level of healthcare. So this was a middle income country and obviously the needs and the expectations of the community are very different in a middle income country than

they are in Sub-Saharan Africa. So for instance if you decide that you need to do a vaccination campaign where we are working in the countries around Syria and Lebanon and Jordan getting access to say the Pneumococcal vaccine is $30 a dose versus the pennies to just a few dollars that we would have access to those supplies in the poor countries. So logistically, financially in terms of our resources it's very different and you are right our resources are incredibly stretched at this point. A colleagues said to me jokingly I don't want to go to the Paris office this summer because I know I will be sent to the field immediately.

Mark Masselli: Back in 1971 you had 13 physicians and as you just mentioned today you employ some 30,000 health professionals and support staff all over the world. So tell us a little bit first of all about the types of people that are coming to you who were offering their services sort of is there a screening mechanism that gets used and then sort of down into the internal workings the logistics of your field mission teams of doctors and nurses and support staff how those are structured and how do you get them ready for medical missions?

Dr. Deane Marchbein: First of all it's a global organization so we are recruiting around the world. So for instance if we have a project in the Democratic Republic of Congo we may identify people in that project who are really strong, capable people and we may incorporate them into our international pool of volunteers. We require that people have professional experience in the area that they are purporting to go to. A doctor would already have to be a doctor and have worked in their area of specialties for things like logistics experts they also have a test and the test attempts to analyze their ability to solve the kinds of problems that they are going to encounter in the field. And but more importantly how they think about things, their flexibility of mind, their ability to take experiences that they've had in one setting and apply them to another. And then there is training that happens before they go to the field but honestly the best training that people get is the handover the one on one training in the field. And one of the things about MSF is it's really not the kind of rigid bureaucracy that you might imagine in such a large organization. And there's a lot of really grassroots experimentation and working out different problems in the field that then gets reported and incorporated into a broader space and exported to different projects.

Margaret Flinter: Our organization started not at such a different time with a great idea and a mission and certainly we are well familiar with all organizations that seek to do good in the world. Start with a great idea and the challenges of infrastructure catch up with you as you're growing and expanding. So we'd be really curious to hear from your perspective what have been the major changes within doctors without borders. What has really carried through from the beginning?

Dr. Deane Marchbein: There are lots of good ideas in the world and there are lots of people who want to do good. But the measure of your success is how much good do you really do. And when they first started and I look at what the first volunteers did they literally came with the medical bags that they could carry into places like Afghanistan crossing the mountains. And when I think about the sophisticated kind of medical care that I have personally delivered in some of the places very remote places but we delivered it. I think about how amazing it is that we've been able to do that. And first and foremost I think it's our logistics. So I'll give you an example I got a phone call a few hours after the earthquake in Haiti and at the same time that I was dispatched from Boston to Port-au-Prince a plane left our logistic center in (inaudible 12:21) and on it, it had an inflatable hospital with everything that you could possibly imagine that would be needed for a hospital. So there's -- this great thought process that went into if I have a color epidemic, if I have a surgical emergency what kind of hospital do I need. And so all of that has been carefully thought out and is ready to go. So I think the logistics is really important and when I go to field all I take is myself and know that there is systemization of the material that I will find there and that allows me to really hit the ground running. And it's delivering medical care to the people most in need. We may have disagreements about what those needs are or how best to do it but we're all focused on the patients that we treat.

Mark Masselli: We're speaking with Dr. Dean Marchbein, President of the Board of Directors of Doctors Without Borders USA, international organization dedicate offering healthcare and medical training in war torn and impoverish countries around the world. We talked about hitting the ground and we hit the ground most often you're running into women and children who have suffered the most and are most in need. And so you're dealing with a lot of maternal and child health issues. I would expect you've got the logistics and the technology there but I'm certainly interested in the cultural competency that comes in where people approach these issues in different ways. How well equipped are you in that sort of cultural context to deliver care?

Dr. Deane Marchbein: Actually I think the cultural component and competency and awareness and sensitivity is super important. There's always a cultural briefing but you would have to ask our patients and the people where we work about our cultural competency because I'm not sure that I can answer that question. But a perfect example of how important that cultural sensitivity is was Afghanistan basically in a state of war and conflict for the last 25 or 30 years with some of the world's highest maternal mortality figures. And one of the places that we opted to work is a town called (inaudible 14:42) which is on the border with Pakistan. And so the team that was investigating what kind of mission we should do sat down with the community, sat down with men, sat down with women to let them decide and inform us about what their most pressing health needs were. And it was the community that said we really need help

with maternal health because the levels of maternal mortality are just unacceptable. And so we opted open maternal hospital and more than that we would staff it entirely with female staff in a place where education has not been in the forefront of their agenda especially for women for the last 30 years. So there were international staff that came and each of the international staffs job was to train local people to do their jobs. Midwife needed to be trained obstetricians or doctors with obstetrical skills. The guards who would check every person entering the hospital for weapons needed to be women and they needed to be trained. And during the time that we have been there which I think is almost two years now there has not been a single death of a mother who arrived at our hospital not already practically dead. When you're doing 12 to 15,000 deliveries a year it doesn't take very long before you've had a major impact on the community.

Margaret Flinter: Well that kind of directly segways into what I wanted to ask you about which is really population health which we certainly are talking a lot about in the United States certainly population health takes on a whole new meaning in the areas where you are working. And I know that you've had some such as your campaign for essential medicines and your nutrition programs in Sub-Saharan Africa and elsewhere. I mean, tell us what you've learnt about successful population health management in some of these targeted zones, you know, maybe you could share some success stories about both what your organization and the other NGOs and entities that are working to achieve the goals of the UN Millennium project or learning from this experience.

Dr. Deane Marchbein: The reason that we decided that we needed a campaign to assure access to essential medications was because we found that in the field we did not have access to the kinds of medicines that we needed or either too expensive or they were simply not geared toward the needs of the populations that we were addressing. And so that was really the basis for the campaign for a essential medicines. The UN Millennium goals are a little bit different, our goals are a little bit different from the millennium goals. The millennium goals are basically to increase human wellbeing over a period of time through economic and social development. And MSF is an emergency organization so some of our work can and does contribute to global strategy. So one of the global goals is reducing childhood mortality and one of the projects that we have implemented is seasonal malarial chemoprophylaxis and so it's an approach that you go to a place that has seasonal malaria where there is a very high mortality deaths especially in children under 5 years old.

These are children often with comorbidity that includes malnutrition and anemia and in addition to taking the usual preventive measures to prevent mosquito bites and you treat them with medicines during that period of time. It's been a huge success. So we started it first in Niger and it's now being trialed in a number of other places and the results have been so exciting that recently UNITAID announced a $67.4 million grant to the malaria consortium to implement seasonal malaria prophylaxis in places like Burkina

Faso and Chad and Guinea, Mali, Niger, Nigeria and Gambia. And according to UNITAID they are expecting that this will protect 7.5 million children and it's estimated that this will prevent 50,000 deaths. So this is an area where the access campaign the millennium project and the goals found an area of corresponding interest in work.

Mark Masselli: We have been speaking today with Dr. Deane Marchbein President of the Board of Directors of Doctors Without Borders USA known internationally as Médecins Sans Frontières an international organization dedicated to offering healthcare and medical training in war torn and impoverish countries around the world. You can learn more about their work by going to Doctorswithoutborders.org. Dr. Marchbein thank you so much for joining us on Conversations on Healthcare.

Dr. Deane Marchbein: Thank you very much for having me.

Margaret Flinter: At Conversation on Healthcare we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.Org a nonpartisan nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori what have you got for us this week?

Lori Robertson: Well we continue to feed democrats and republicans attack each other over the Affordable Care Act and Medicare. For instance in the Montana senath race and ads from the republican candidate Steve Daines features a 67 year old breast cancer survivor who says the ACA puts her Medicare at risk. Meanwhile an ad from the democratic candidates centered at John Walsh features a senor woman pointing that Daines voted to cut Medicare benefits. We are seeing similar misleading Medicare claims and races across the country. First the republican ad the claim about the breast cancer survivors Medicare being at risk is based on a tired attack that democrats cut more than 700 billon dollars for Medicare to pay for Obama Care.

The Affordable Care Act doesn't flash 700 billion dollars from the current Medicare budget instead this is a cut in future growth of spending over a decade. And a slower rate of growth which applies to payments made to hospitals and other non-physician providers extends the solvency of the program. It remains to be seen whether this would translate into reduced services. In terms of breast cancer however the ACA expanded benefits from mammograms covering them fully without cost sharing for Medicare beneficiaries on a yearly basis.

Now the democratic ad, it features three senor women, one of whom says that representative Daines voted to cut Medicare benefits. A reference to Daines's vote for representative Paul Ryan's Budget Plan. Ryan's proposal for Medicare would mix the ACA's free preventive care including cancer screenings and flu shots and it would get rid of the law's closing of the prescription drug donut hole. But relatively a few seniors

have a drug cost high enough to put them in that coverage gap. So far roughly 16% of Medicare beneficiaries have saved money on prescriptions. Thanks to the ACA's extended benefits and that's my fact check for this week. I am Lori Robertson, managing editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like checked email us at chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Healthcare.

Each week conversations highlight's a bright idea about how to make wellness a part of our communities in everyday lives. One of the conditions that results from the tens of millions of surgeries that take place in this country every year is called Postoperative Ileus a condition which causes the intestines to shut down temporarily due to the trauma of surgery in the effects of exposure due to anesthesia. Put simply patients could become dangerously ill if given solid food too soon after surgery which can lead to serious complications and longer hospital stays. Up until now there has been no more sophisticated diagnostic tool than the stethoscope where clinicians listen to a patient's belly for a short period of time waiting science of intestinal activity.

Dr. Brandon Spiegel: So this is a major problem because it's so common and the problem is we are not always sure when to feed people. So we either feed too soon in some cases and that can cause problems or we wait too long and people linger in the hospital when they could easily be discharged.

Margaret Flinter: Dr. Brennan Spiegel, professor of the David Geffen School of Medicine at UCLA led the team to develop a new solution AbStats an acoustic gastro intestinal device placed on the patient's abdomen that can monitor the colons activity in real time. Dr Spiegel says the disposable abdominal monitory seem deceptively simple but were the results of a long time collaboration between many departments that UCLA that are working towards a common goal of finding ways to improve healthcare.

Dr. Brandon Spiegel: So we have worked with electrical engineers, we have worked with clinicians, surgeons, gastroenterologists, even health economist to understand what would the role in placing therapy would be for at disposable device of this kind.

Margaret Flinter: Spiegel says with the rising epidemic and obesity as well as intestinal disorders a device like this could become standard diagnostic tool in primary care settings in long-term care as well.

Dr. Brandon Spiegel: As we continue to move forward concurrently in testing it in other types of patients like obese subjects and other common populations like those with irritable bowel syndrome and inflammatory bowel disease and so forth.

Margaret Flinter: The AbStats an inexpensive disposable abdominal sensor that has the capacity to quickly and accurately determine the quality of function in the intestinal track helping in work complications in the post upsetting, improving patient outcomes and saving significant money by avoiding lengthy hospital stays, now that's a bright idea.

Margaret Flinter: This is Conversations on Healthcare. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli. Peace in health.

Conversations on Healthcare broadcast from the campus of WESU at Wesleyan university. Streaming live at wesufm.org and brought to you by the community health center.