David Burda:

Welcome to the 4sight Health Roundup Podcast, 4sight Health's podcast series for healthcare revolutionaries. Outcomes matter, customers count, and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, March 12th. If you're a healthcare executive with the letters F-A-C-H-E after your name and you voted for this, how you feeling right now? Well, if you or someone you know has the measles, probably not too good. We're gonna talk about the measles and its impact on healthcare with Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi, Dave. Hi, Julie. How you two doing this morning? Dave?

David W. Johnson:

We've had Biblical weather in Chicago this week, is pushing 80 degrees early in the week, and then, one, two days later, hail, drenching rain, biblical rains. I literally think I saw the giraffes and elephants and monkeys walking two by two down the street. And what's next? Pestilence, famine. I, you know, I don't know. <Laugh> But anyway; Welcome to Chicago in March.

Burda:

Yeah, I saw some snow flurries yesterday too, so, - <laugh> Yeah, yeah <laugh> pretty crazy.

Johnson:

Yeah. Hail then snow. Yeah. Exactly.

Burda:

Great. Julie, how are you? Hopefully warmer than we are.

Julie Murchinson:

Well I am in our nation's capital and it is warm here, but I am noticing that the National Guard has not been doing their job because there is just trash all over the place.

Burda:

Ah, ah, ouch. We're gonna talk about something else, the measles. And let's talk about your childhood vaccine history. Dave, did you get all your shots when you were little and, did you ever have the measles?

Johnson:

Well, you know, I'm old, so I came of age, before <laugh> a lot of these great vaccines that are out there now. But the only one I really remember getting is the smallpox shot, which left this big round mark in my left arm. So you could always tell which kids had had it and which kids hadn't. So as a result, I got German measles, regular measles, chickenpox, along with just about everybody else in my immediate circle. Never got mumps or whooping coughs, so maybe I'm still at risk for those. <Laugh>

Burda:

Yeah, I've got one of those scars on my left shoulder too. Thanks, Dave. Julie, how about you? Did you complete your vaccine schedule when you were young and how did you fare?

Murchinson:

Oh, we were a good little compliant family. I was on schedule for every single vaccine possible. And I have to say, the lore in my family is that my grandfather had polio, like, obviously well before I was born. So, you know, vaccines in our family are, like, a miracle, right? To think that, like, you wouldn't, no one would get polio again. So it's,yeah, it's, this is all very difficult for me to, to swallow.

Burda:

I got all the shots that were available at the time, including the measles vaccine and never got the measles, but I did get chickenpox when I was, seven or eight. , I got scars to prove it. The chickenpox vaccine wasn't available until 1995, but all my kids got it so they wouldn't look like me. <Laugh> And that's a good thing. I think we all could agree. <Laugh> All right.

Murchinson:

Yes.

Burda:

Now let's talk about something that's not so good, and that's the current measles outbreak in the US. Let me throw out some numbers and get your reaction. These numbers are as of March 6th, according to the CDC. There were 1,281 confirmed cases of measles so far this year. There were a total of 2,283 cases all of last year. So we're halfway there with more than nine months to go. 31 states reported measles cases so far this year. There have been 12 new outbreaks, which the CDC defines as three or more related cases in one location. 54% of the cases are of people between the ages of five and 19, and 93% of the people who got measles this year were unvaccinated. And that's the good news. Check out these cost figures from a study by the Yale School of Public Health, published late last month in a journal called MedPrescription 14. They said the average cost of a single measles case in 2025 was $104,629 with the total national cost of $224.2 million. That price tag includes the cost of outbreak responses, direct medical costs, and productivity losses. They said if the measles vaccine rate for kids six years or younger goes down by 1% a year, measles cases will surge with the national costs going up to $1.5 billion a year by 2030, or a total of nearly $7.8 billion over that five-year period. Those are some pretty scary figures. Dave, when you add up all these numbers, what does it tell you about the state of our national public health policy right now? And if you ran a state

public health department, what policy levers would you pull to keep your citizens safe?

Johnson:

Well, you know, Forest Gump got it right. Stupid is as stupid does. That litany of numbers you just went through is among the most depressing I've heard in recent times, particularly when you consider that in the year 2000, the WHO declared that the United States had eradicated measles as a disease. Year 2000, by the way, was the last time we had a budget surplus, federal budget surplus. Is there any way we can go back in time? Because it sure feels like Idiocracy since then. Regarding those cost numbers, the great founding father, Ben Franklin, said an ounce of prevention is worth a pound of cure and there are, 16 ounces in each pound, so that's a 16X return; pretty good. Well, a typical MMR vaccine, which includes measles, costs about 100 bucks, and if those cost figures are right, each measles case costs 100,000. So that is a thousand to one return.Why <laugh> aren't we providing this enormous benefit to society more broadly? And we really can't trust the federal government right now because of everything that's happened at the CDC and with RFK, you know, anti-vax champion head of HHS, and it seems like he cares about that more than just about anything else. So what would I do if I were running a state health agency? Good question. I think the first thing is I would use, my megaphone, my public megaphone, my bully pulpit, to articulate and amplify the current state, the problems, the solutions, and just be out there nonstop talking about it. New York City has a relatively new health commissioner, Ellister McClain, and I was reading an interview by him on MedPage this week, and he got asked the, the question, Dave, I bet you asked it a million times, "…what keeps you up at night?"

Johnson:

Right. Yeah. Let me just read what he said in the interview: "I have to tell you, one thing that's really worrying me is the way the federal

government and the federal administration is dealing with public health education and vaccine guidance. I think to say it bluntly, what the federal government is doing with vaccine guidance is creating a public health disaster. We are seeing it very clearly in the actions that they've taken, taking us out of the World Health Organization, effectively gutting the CDC, muddling the language with regard to recommendations around trusted and proven vaccines. The reality is we are already seeing here in the city declining rates of vaccinations and other, very, very key metrics." And he goes on to discuss those and then he finally says, "But we're not waiting for the federal government to come in and tell us what to do." And this was what blew me away. New York City joined the WHO, the World Health Organization two weeks ago.

Burda:

Really?

Johnson:

Yeah.

Burda:

Wow. I didn't know you could do that directly. That's great.

Johnson:

Yeah. So, you know, use that bully pulpit, get out there, tell the truth, and do everything you can do, conceivably to help persuade the public to follow proven advice. And, you know I've been worried about South Carolina, right? They had that measles outbreak in sort of the northern, north western part of South Carolina around Spartanburg. So because we were doing this, I decided to go to the public health website for the state of South Carolina. And surprisingly, it was pretty good. I mean, you go to the page on the measles, dashboard outbreak, and they got the key takeaways, and the first couple just go into how contagious measles is.

And then it makes this very logical statement: “The measles vaccine MMR and MMRV is the best way to protect yourself and others against measles.” And then they have a chart that goes through the measles vaccine. What does it prevent? How does it work? How well does it work? Very well. Is it safe? Yes, very safe. And then it goes in, who should not get the vaccine? Well, it's very few people. What's in the vaccine? Here's my favorite part of that description. What's not in the vaccine? No mRNA, no aluminum, no preservatives <laugh>- <laugh> ... And, and no fetal tissue. So, you know, <laugh> they're clearly aware of who their audience is. And I suppose the good news there is when you go to the dashboard, it does look like that epidemic has burned itself out. It got up to almost a thousand cases, but there haven't been any new cases in the last couple of weeks. And they produce results every Tuesday and Friday. So, I think the answer to your question is, if you can't trust the federal government, go local.

Burda:

Accurate information is out there. We just have to make it easier for people to find, I guess. That great, Dave. Thank you. Julie, any questions for Dave?

Murchinson:

Yeah, Dave, <laugh> yeah, you're gonna love what I have to say, that's for sure. <Laugh>

Johnson:

I bet I will. I usually do. <Laugh>

Murchinson:

So this, you know, MedRx modeling that they did had to stitch together county level data, outbreak incidents, economic inputs, like a ton of data from multiple fragmented sources. If you were to think about how you'd prioritize data infrastructure in our public health system today, where

would it fall in the priority set given, you know, what you just shared about the top priorities and is there other data you'd pull in to help target solutions better?

Johnson:

Yeah. Well, honestly, getting a unified dataset would be priority one. We have an ability now using the machines to collect the data, let the intelligence platforms go wild to some extent to get all the sources we can to figure out what we need and to put it in a coherent place where any and all can access it. So I would hope that some of these public health departments are trying to figure out how to take advantage of this incredible data technology we have. There's almost a singularity to these data systems, these self-learning, these self-actualizing platforms that's like DNA. DNA configures itself to whatever the environmental need. If you've got the unified data layer, then the intelligence platform with the ability to do algorithms, gain insights on top of that, combined with applications to engaged end users, the only thing holding us back is our imagination as to what we can apply that to. We can configure data to discover, solve, and inform people on public health issues, along with any number of other things.

Burda:

That's a much better way to use AI than blowing up schools, right? <Laugh>

Johnson:

Bring us back up, Dave, as always. There we go.

Burda:

I'm trying. I'm trying. All right, Julie. What's your take on these figures from the CDC and the Yale study? Is there anything the market can do to tamp down these outbreaks and prevent them from breaking the bank?

Murchinson:

There's a strong case that markets can absolutely help tamp down breakouts and keep the price tag from all this from exploding if they're pointed at the right levers. So I'll share a few things I think we could do, but I frankly think we just have, like, much bigger issues at hand. The way we would normally consider addressing this kind of situation is through some sort of top-down framework of incentivizing, you know, actors in the healthcare system broadly to do things to make vaccinations happen, right? So we could align health plan incentives with higher MMR coverage. You know, today, most of the cost is borne by the public health system, so plans probably aren't really investing like they could be in prevention in this area. So you could imagine, like, baking childhood MMR coverage into star ratings and quality bonuses and employer RFPs and things like that, or creating benefit design where, I mean, this gets, you know, this could be more effective perhaps, but for you to have zero copays or even better, actually cash or some sort of premium incentives for families that complete the two dose MMR series and maybe focus out on high risk counties. So, you know, those kinds of things we could, we could and frankly should do. <Laugh> I also think we could and should consider how to use employers and schools as, you know, distribution and demand engines. Like, if you looked at some of the data around, the rate among kindergartners that's dropped, it's dropped enough that we have now hundreds of thousands of kindergartners at greater risk in the last few years, right? So you could see employer-sponsored, MMR drives, you know, having employers really make it easy and convenient for their employees or education sector focused contracting, you know, where you could just kind of buy an immunization compliance services sort. So you could do all these things, and I'm sure many, many more things that I didn't really think about, but I don't know if it would help because I, yeah, I was part of this group last week that was discussing consumer trust in healthcare. And I'll tell you what, we, of the healthcare fabric have no idea how to fix this. Like, we were talking about things like pulling in celebrity

influencers and creating social media influencers or engaging them and teaching scientists and doctors how to be better communicators. I mean, okay, these aren't all bad ideas, but I mean, the subpar ideas, I felt like were a plenty. And, you know, we had this speaker come in and talk about how your best communicators are really your employees, like the people in your own organization who can send the messages for you. And, you know, we've burned these people out. We get in union driven fights constantly with them. We're always fighting over compensation, workplace violence, all the things that make our employees not be good communicators on healthcare's behalf. And then we spent the last 50 years providing, you know, mostly friction filled healthcare experiences and, and the people are over it, right? Like, we know this. We've told them that their doctor can make them better and heal all wounds, but we totally screwed that up during COVID and we had been screwing that up for years prior to that. So, you know, not only did we, like, keep dads out of delivery rooms and force patients to die by themselves, but we actually have made vaccines that have created issues, even though I think most of that has been inappropriately directed towards vaccines. Like, we have created issues, we have a trust problem. So, Dave, what you started to ... The road you started to walk down around fixing misinformation or, you know, developing marketing and, and counter-narratives- Yeah. ... Using public health people, I do think we could, you know, <laugh> pay local pediatricians and faith leaders and folks like that, or use social media platforms to send, you know, pay social media platforms to publish high quality vaccine content, right? But I just don't know that we can materially dig ourselves out of the trust hole that we've been digging for decades. It's scary.

Burda:

A good friend of ours is a retired school nurse, and she saw a change in parents, right?

Murchinson:

Yeah.

Burda:

Seeking ex- exemptions for their kids from vaccines and putting up a stink. And so, , if you can't trust your school nurse, who you gotta trust? Great, great points. Thanks, Julie. Dave, any questions for Julie?

Johnson:

Julie, our, looks like our next surgeon general as a social influencer of some renowned is going to be Casey Means. You know, she's from California, west coaster like you. Will Casey Means be more helpful or harmful in addressing the nation's roiling debate over vaccines generally?

Murchinson:

That is such a good question, Dave, because I don't know if she's gonna be helpful or more harmful, but I think she's gonna be rational and logical. Like, so maybe that's the best we can hope for <laugh> right now. <Laugh> I don't know. , You know, she's a very, , it, ... I think of her as, like, focusing on holistic health, metabolic health. Like- Yeah. ... The things that are really about the MAHA agenda or related to the MAHA agenda, and I think, on the vaccine front, like, I get the sense that… She probably doesn't think about drugs and vaccines as solving all of our health ills, but my guess is that she's, you know, she's a well-educated person who probably thinks in a very nuanced way about how to use tools like vaccines. , So I, I think she'll bring sanity to this. I don't think it's gonna be her sword to die on to fight RFK on it though.

Burda:

You know, this anti-vax stuff really perplexes me. You know, why do we always wanna go back to the 1950s? You know, why don't we just

stop making bike helmets and outlaw seatbelts in cars? All right. Now let's talk about other big healthcare news that happened this week. Julie, what else happened that we should know about?

Murchinson:

Well, it was only, like, what, six or eight weeks ago when we started talking about Thoreau, but it is now flamed out and Matt Holt has left New Mountain Capital, so new chapter.

Johnson:

Wow. I hadn't heard that. Wow.

Murchinson:

Yeah. <Laugh>

Burda:

Me neither. That was fast.

Murchinson:

Yeah. Yeah.

Burda:

Oh, okay. All right. And this is gonna be the first thing I look up when we're done here. <Laugh>

Murchinson:

You heard it here first.

Burda:

Yeah. Breaking news. Thank you. Dave, what's your big healthcare news of the week?

Johnson:

Well, I'm still chuckling myself to your observation about going back to the 1950s and the old joke that everyone wants to go back there. Republicans wanna live there and Democrats wanna work there, so there you go. <Laugh>, But my big news for the week is the Trump administration is coming up with a new type of Medicare Advantage plan that won't have a provider network. You know, essentially, those offering these plans will announce their prices for specific procedures and let the market figure out how to provide them at those prices. And it's intriguing because if it gets enough scale, it could actually change supply demand dynamics. On the other hand, it really exposes people in high deductible plans to some surprises that we're very used to. So anyway, something to pay attention to, maybe even do a program on at some point in the future.

Burda:

Very interesting. Thanks, Dave. And thank you, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. You also can subscribe to the Roundup on Spotify, Apple Podcast, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.