4sight Health Roundup Podcast
Right Diagnosis, Wrong Treatment Plan
4/10/25

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 Berta, news editor at Foresight Health. It is Thursday, April 10th, having fun. Yet, I hope you don't get accidentally snatched off the street by ice and sent to a prison in El Salvador without being read your rights or any due process of law, because if you do, you're sure as hell not coming back. At least not according to our own Justice Department and the US Supreme Court. Good luck. You know, if we had a soundtrack for this episode, I'd queue up a Life During Wartime by the Talking Heads, anyway. I'd never been in a prison in El Salvador, but I have been to a lot of hospital emergency rooms over the years for various reasons. I think the two have a lot in common. Unfortunately, we're gonna talk about emergency care in the us Thanks to a new report from the Rand Corporation and there's your long away to transition to share. Their takeaways from the new report are Dave Johnson, founder and CEO 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi Dave. Hi, Julie. How you two doing this morning, Dave?

David W. Johnson:
Well, I'm doing great. I'm in Aspen for the Cain Brothers Life Sciences conference, and I don't think there's any better place in springtime the mountains in springtime, and I'm going fly fishing this afternoon. Life is good.

Burda:
Yeah sounds good. Julie, how are you?

Julie Murchinson:
I'm doing great. I'm in actually Laguna for the week for Health Evolution, and they had Mehmet Oz, kick it off yesterday. It's quite the show.

Burda:
Did Medicare Advantage come up?

Murchinson:
Yes. It has come up throughout the hallways in multiple instances, <laugh>, <laugh>,

Johnson:
Are you more or less confident in the ability of the administration to address our healthcare systems issues?

Murchinson:
I definitely, I find myself more MAHA, gotta tell you. But, there's only so much real estate he can influence, so it's great talk track. It's just a lot, you know, it's a lot different when you try to figure out what lever you should pull.

Burda:
Yeah. Yeah. Kinda like his show, right?

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Murchinson:
<Laugh>. Yeah,

Burda:
<Laugh>. There you go. All right. Before we talk about this new report on emergency care, let's talk about your, your last visit to the ER Dave, I don't need specifics, but how long was your wait time, the last time you were in the emergency room?

Johnson:
Well, it, it was a long time ago, and I was worried I had a concussion but I wasn't a high triage <inaudible> <laugh>. I walked into the ER at Advocate which is near our house Advocate Masonic. I waited around for about three hours and concluded they were never gonna get to me, and just went home and hoped when I fell asleep, I was gonna wake up the next morning, which I did. So <laugh>

Burda:
Oh, rolling the dice there, Dave. Julie, how about you? The last time you were in the ER for yourself or someone else? How long did you have to wait?

Murchinson:
Well, I think as you both do know, I was in the ER recently, unfortunately, but for I think good reason and all is well, of course that was the quickest thing ever. 'cause It was 11:30 at night and it was, you know, a two and a half hour N 10, which does not feel like a bad experience. But I have been to the ER with my mother a couple different times, and it's been a, you know, six to eight hour adventure just to get into a room. So it's, you know, it's highly variable.

Burda:
Yeah. Yeah. That's like my experience. The last time I was in for myself, it was about six hours which wasn't too bad, but by the time I left, the wait time was up to nine hours. And, and like you, Dave, when people heard nine hours, they were walking out the door the other direction. Okay, let's talk about this new report from Rand on the sustainability of emergency care in the US . It's getting a lot of attention in the healthcare trade press. Let me share some of the key findings and recommendations from the report, and then get your reaction. Dave, did we learn anything new from this report that we couldn't get from an episode of the Pit? And from a policy perspective, how can we improve emergency care in the US without throwing more money at the problem?

Johnson:
No, we didn't. We didn't learn anything. And as you know, I am a fan of the pit. I can't wait for the final episode of the season. What is it in, in in trials where the defense accepts the diagnosis or the facts of the, of the prosecution, but then tries to shift the argument. Anyway, I accept the diagnosis. We have a piecemeal approach to healthcare in this country that's fragmented. The ED has become a catchall for many of the U.S. healthcare systems failures related to coverage and access. I give them all of that. Although if you go to the University of Chicago ED, as I was just

told recently, it is right out of an episode of the pit that people are there for days wow. To address their, their conditions. So I, I'm gonna go a little big picture. There used to be this show on MTV called Pimp My Ride, either of you remember that?

Burda:
That's… you're going back ways. Yeah.

Johnson:
Right, right. And, and basically what you would do is you would take a jalopy and then put all kinds of customized features on it, you know, new paint, job, sound system, so on, and you would end up with this car that looked great on the outside, but underneath was still a jalopy. And I think when I look at the recommendations here, we've got a version of Pimp My Ride here. We've, we've got a jalopy of a health system. And the idea that we just throw more money at ED will, will solve anything is crazy. It's at best a Band-Aid and it's a very expensive way to try to improve the overall health of the country. So the idea when you have systemic failure is to take on a systemic solution. And so without, you know, getting too much into the, the details, I would thank them for their work, even though it's self-interested. You, did mention that <laugh>, <laugh>, those that paid for the study would benefit from the new investment. Nothing new there in U.S. healthcare.

Murchinson:
Right?

Johnson:
So, you know, pointing out the obvious flaws in the system, but then suggesting a piecemeal incremental approach as a way to address systemic failure just is not gonna work. So I wouldn't spend a whole lot of time reading this above and beyond what we've done at this point. Compliment them for their diagnosis, wish them well, and don't do what they say.

Burda:
I think you have the right treatment plan, Dave. That's great. Thank you. Julie, any questions for Dave?

Murchinson:
So Dave I share your disappointment here, but if you're right that ED challenges are part of a larger systemic failure, then what's the right way to think about addressing change in here?

Johnson:
I happen to be in Aspen, and this, the Aspen Institute is where Walter Isaacson was the president for a long time, one of the great historians biographers in the country right now. And his first book was called Wise Men. And it was about six six men who helped remake the post-war world. And I'm gonna read a passage from a letter that George Keenan wrote to the Secretary of State at the time, Dean Atcheson, about what to do after the catastrophic failure of MacArthur's attempt to win the Korean War by hopping up the coast that ultimately brought China into the war. And created a strategic dilemma of monumental proportions. So the administration was

reeling. And Keenan wrote this letter to Atcheson, where he says, in international, as in private life, what counts most is not really what happens to someone, but how he bears what happens to him. For this reason, almost everything depends from here on out, on the manner in which we Americans bear what is unquestionably a major failure and disaster to our national fortunes. If we accept it with candor, with dignity, with the resolve to absorb its lessons, and to make it good by red redoubled and determined efforts starting all over again if necessary, along the pattern of Pearl Harbor, we need lose neither our self-confidence, nor our allies, nor our power for bargaining. But if we try to conceal from our own people, or from our allies, the full measure of our misfortune, or permit ourselves to seek relief in any reactions, a bluster or petulance or hysteria, we can easily find this crisis resolving itself into an irreparable deterioration of our world position, and of our confidence in ourselves. And I think about this passage sometimes when thinking about the healthcare 'cause we have anything but that type of, of candor and redetermined effort. We have groups like this that are looking out for their own interests that take a slice of the problem and, and appear to give a beneficial solution. But up and until we go back to the studs and think about how do we design a system that's, is at its basis an American system that addresses the health and healthcare needs of the people. We're just, we're just floundering.

Burda:
What a letter. Could be dated April 10th, 2025 <laugh> after what happened this week. Yeah. with our economic system.

Murchinson:
I mean, honestly <laugh>

Burda:
Oh boy.

Johnson:
We have no bluster in this country right now. <Laugh> or Ululate or hysteria. We have none of those things.

Burda:
Thanks Dave. Okay, Julie, it's your turn. Did you learn anything new from the report that you didn't know already? And from a market innovation standpoint, how can we improve emergency care in the US other than just throwing more money at it?

Murchinson:
<Laugh>? No, this report is kind of the epitome of what's so disappointing about our healthcare apparatus. Nothing much new either on from my side. And there have been so many approaches, you know, to reduce unnecessary ED beyond just patient education. I mean that so many digital health tools used in various ways, ED diversion models a lot, <laugh>. And, you know, when I really sat down to look at some of the companies that we've seen, and even kind of recent talks I've been to on ED version models, digital health honestly could play a crucial role here. You know Teladoc and AMO and MGLive and all those really early virtual care models you know, one of their key use cases was triaged to the right side of care and looking at this problem. So a

lot of those virtual models are born on this concept. You know, real time monitoring has been meant to help avoid downstream issues and try to address upstream. Amada, Livongo, Biopharmas even, you know, companies that are focused on the populations that can be frequent flyers, so to speak, in the ED. I think there's more opportunity for you know, products or online symptom checkers and assessment tools that not only educate patients, but can help patients really understand whether the issue they have is an emergency and alternate sites of care they may consider. And I actually think this is an enormous opportunity because there hasn't been great uptake of these kinds of tools, but they have shown to make a small dent. So I think there's more to be done there. And, you know, whether you're a dispatch health, working in, kind of, on demand mobile care MedArrive heal some of the early OG companies that we're trying to provide alternative approaches for people with limited mobility or the care coordinators out on the streets pounding the pavement, like city block, trying to help high risk populations find stable providers so they don't end up in the ED. These have all been a lot of very upstream solutions that have had a big impact, honestly. But it doesn't always compute for people that they have those options. When the ED is kind of an easy button. And I mean, let's face it, behavioral health is kind of the elephant in the room. Like, it's the, it's the one thing, honestly, that I think has created so many of our, our ED jamming issues around the country. And there are very few models, unfortunately, that can really absorb those patients that are sitting in the ED waiting for a room, waiting for a transfer to an acute care center. And that's where we need to put upstream models in place because we don't have the capacity upstream or in any acute capacity to really deal with that. And I think that's, you know, it is just exacerbated the problems over the years. But the businesses that I think have really not quite hit the mark yet, but I'm seeing more every day, are these ED diversion businesses. And I just saw a company called Right Site last week, and I've seen a few of these, but they try to intervene when there's a 911 call that comes in. And the challenge hasn't necessarily been capturing people when they come into the 911 call and triaging them. But some of the earlier models haven't had the right kind of service model and landing spot for people to get diverted out of 911 to a different level of care. And this company right site actually has something pretty interesting. So I have hope that, you know, working with our social service systems like 911 we could actually, you know, do a lot more active navigation. So, you know, I think there's a lot there. I'm just disappointed in this a report like this, because you just know it's getting shocked around the hill like crazy. This is what's being used to educate our lawmakers, and it's just where are, why are we not putting together a whole report on everything that I just talked about?

Burda:
Thanks Julie. Great. suggestions. Dave, any questions for Julie?

Johnson:
Well Julie, you described many different ways of going about it, is part of a <laugh> of what we need to do is when we do a systemic overhaul of, of the system. But anyway since we're being cynical today why don't you give me your take on standalone EDs and how they fit into the healthcare ecosystem as a whole?

Murchinson:

Yeah, it's such a great question because standalone EDs from my perspective, have created a lot of access. So I don't know that a lot more access of freestanding emergency departments that are effectively highly profitable for most of their owners. I think some of the PE-backed you know businesses have struggled a little bit more than the hospital owned. But if they're located in a place where they can pick up favorable payer mix they can see more patients. So they're actually, you know, they have a higher throughput, which makes them a better business. Typically the hospital associated ones can bill hospital rates and they're sitting on a much lower footprint. So I just look at these as access vehicles that actually potentially exacerbate, you know, the problem because it's just a bunch of high cost care that's more available closer to you. And honestly, some of the health systems have used them really strategically to pull revenue and referrals into their systems. So I'm not so sure I see that as a solution.

Burda:
Yeah. If you build it, they will come. Right?

Murchinson:
That's right. <Laugh>

Burda:
Back to baseball.

Johnson:
Even more importantly, they will pay, right?

Burda:
Right, right. Yeah. Yep. Thanks Julie. Dave, I did start watching the Pit as you recommended a few weeks ago, and I understand why you watch only one episode at a time, <laugh>, because I think if I binge watched it, I'd end up back in the emergency room. So…

Johnson:
It's pretty intense.

Burda:
Okay, let's talk about other healthcare news that happened this week. It wasn't all bad, was it, Julie? What else happened in healthcare that we should know about?

Murchinson:
Well, I mean, I think the topic of du jour around here, definitely the Medicare rates what came out this week was a blessing for MA gives it some new life and talk of the town, that's for sure.

Burda:
Yeah. What was it? A five, five point something increase in payment rates. Right.

Murchinson:
Almost double the expectation.

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Burda:
Wow.

Murchinson:
Wow.

Burda:
Yeah. <laugh>

Murchinson:
Pretty different mood than last year.

Burda:
It's like robbing the bank and then the bank teller says, Hey, you forgot some.

Murchinson:
Yeah,

Burda:
<Laugh>. Unbelievable. Dave, what healthcare news hit your radar?

Johnson:
We seem to be on a cynical track this morning, so I am not gonna deviate from that. One of the things that came out this week was an announcement by Undo Medical Debt of a blockbuster deal to wipe out 30 billion in medical debt that they're buying from Pendrick Capital Partners. First of all, Pendrick is a PE company that buys medical debt and tries to collect. So, Snidely Whiplash with, with Dough, but 30 billion of debt that nobody's gonna collect that on average is over seven years old is just another example of people highlighting a problem and not having a solution that actually addresses, in this case, anything.

Burda:
You exposed Undo Medical a few weeks ago and a great piece. You were all over that and called it the right way. Thanks Dave, and thanks, 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@ 4sight health.com. You also can subscribe to the roundup on Spotify, Apple Podcasts, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening on Dave Burda for 4sight Health.