Primary Care Cures
Episode 95: Michael Akinyele

Ron Barshop:
This episode is brought to you by the MediSearch Institute. What happens when patients cases become too complex to solve in a typical 30-minute visit? Well, we've all had those super thick, super deep patient history nobody's looked at in a long time and gone back through. Well, I'll tell you what happened is those patients bounce around from doc to doc without getting any answers or making any progress. These patients are trapped and lost in a maze.

Ron Barshop:
Well, MediSearch is here for those doctors and for those patients. Their motto is we solve the unsolvable. Their process is rather simple. Dr. Trent Talbot, the founder, assigns a team of medical detectives, typically three MDs and one PhD to each case. They research the latest breakthroughs and clinical trials and they elicit the opinions of 10 to 15 world-leading experts per case. They purposely seek out experts who will come at each case from a different perspective, the Bayesian method. Altogether, they will put in over 250 MD hours for every case. That means 500 times the amount of brain power that typical doctor can afford to offer.

Ron Barshop:
You know most problems in health care are fixed already. Primary care is already cured on the fringes, reversing burnout, physician shortages, bad business models, forced buyouts, factory medicine, high deductible insurance squeezes the docs and is totally inaccessible to most of the employees. The big squeeze is always on for docs. It's the acceleration of cost, deceleration of reimbursements. I want you to meet those in this show that are making a difference. With us, Ron Barshop, CEO of Beacon Clinics, that's me.

Ron Barshop:

It was 101 years ago when we lost my great-grandfather to the Spanish flu, our last great pandemic. Samuel Barshop made those little wooden desks that you could barely fit in with his brothers in the Flatiron Building in Manhattan. And the couple also lost their infant, Dorothy, to the Spanish flu at the same time they lost the father, the chief breadwinner. So in 1918, this forced my grandfather, Papa Joe, to be the breadwinner at age 14 for an immigrant family of five in the heart of New York City. He worked in accounting in ladies' ready-to-wear, and eventually he sold produce to the South Texas grocers, like H-E-B and Piggly Wiggly.

Ron Barshop:

He formed the first Texas condo association in the state in 1952. It's called Produce Terminal. He and other vendors could now sell from not only a central Depot that they all shared, but it had refrigeration down below in all their locations, and it had docks for loading and rail loading as well. And they could trade with each other to fill the orders for customers. It beats selling from the booth at what was now known as El Mercado, which is also if you're not a local from San Antonio known as the Historic Market Square. But maybe you've enjoyed a Tex-Mex dinner

there at La Margarita or Mi Tierra restaurant, which are two of the most profitable restaurants in the state of Texas. My Papa Joe, my grandfather, he knew the pandemic life, and it formed him. And I feel deeply connected across the century to my grandfather.

Ron Barshop:

Our guest today, Michael Akinyele was the founding chief innovation officer for the US Department of Veteran Affairs, the VA. It's the largest civilian federal agency with $250 billion budget and almost 400,000 employees at over a thousand centers, and he was responsible for leading and transforming and scaling enterprise innovation at the department for the first time.

Ron Barshop:

His efforts were as a principle lead of the VA innovation center, known as the VIC, and served in that capacity from March 2018 till late this year. Michael is the founder and managing principal today of the Maximizer Group, which is an independent advisory firm, primarily advising corporations, investors, and startups. He's a healthcare futurist, a collaborative leader, a product and growth expert. And he's focused on investing in a future where everybody wins, something you get if you listened to this show.

Ron Barshop:

Before the VA, his most recent full-time role was serving as director of venture development for a $2 billion asset fund that distributed 125 million in investments yearly. And he, in the healthcare industry, has advised such a wide swath of people that it's just such a long list. But it's health systems and physician groups and academic medical centers and big healthcare, big plans, big pharma, PBMs, and even a Medicaid agency. And he's managed physician practices. He got his a master's in business at Stanford, and he graduated Magna cum laude at his undergrad university.

Ron Barshop:

So Michael, welcome to the show.

Michael Akinyele:

Thank you, Ron. And thank you for that very detailed overview. Appreciate it.

Ron Barshop:

Well, you're welcome. Michael, I don't really know how we're going to get this done in half an hour. Because when we talk, we go way past a half hour because there's so many interesting topics. But let's try to narrow this to two subjects. And I think the first one is the VA is probably the best precursor to what a single payer system will look like, because it is exactly that in our economy, and it's a big one. The second thing I want to talk about is what I opened the show with, which is how COVID has changed the patient experience forever, the doctor experience forever, the hospital system experience forever. What are the big changes we can see? Because you have this massive 20,000 foot view with your background. You want to tackle those two subjects with me today?

Michael Akinyele:

Yeah. Yeah, absolutely. Those are very weighty subjects, and I'm sure we won't get in trouble at all talking about them.

Ron Barshop:

Oh. Well, the VA is so easy to poke holes in because it's so big. It's so hard for them to recruit doctors to compete with the commercial industry, isn't it?

Michael Akinyele:

I think the situation is very, very complicated. And the challenge is one of incentives being one part of it, right? So if you're not able to pay physicians at the same rate as folks in the private sector can pay, you're ultimately asking folks to make that type of financial sacrifice to come and to work within the VA system. So that makes, in some instances, recruiting very challenging. That's been a well-known problem. And Congress has taken a lot of actions recently trying to sweeten the incentive package, so everything from loan forgiveness to doing everything they can to raise the cap on compensation.

Michael Akinyele:

Ultimately, the VA has to compete, and it has to compete in markets where other health systems are still struggling to recruit certain types of specialties into those markets. The challenge the VA faces is a challenge of any system that's trying to run across the entire country without the ability to build enough of a density that would justify the traditional economics of a business.

Michael Akinyele:

If you look at a system like Kaiser, right, everyone wants to hold up Kaiser. Kaiser gets to pick where it wants to play and built a delivery system accordingly. The mission of the VA is one where we help the veterans where they are, and veterans are in all 50 states. Veterans are also in countries overseas. So the VA's mission is to meet the needs of the veterans where they are, and that is a global mission at this point. And then, obviously, we can delve into COVID or just keep pulling layers on this one, so I'll leave that to you as to where we go.

Ron Barshop:

Well, we can pull for more way past our half hour. I had dinner with friend of mine who's married to a VA physician. She said it took about six months from someone from the moment they had chest pain or some type of angina to actually getting a cardiologist visit because of just the incredible shortage of specialists there. Six months is an eternity when you have angina, and it can lead to all kinds of other problems. But she had to prove beyond a shadow of a doubt that he had not anxiety. It was beyond cumbersome. And she's really, along with a lot of her other primary care doctors, thinking about leaving the VA because she can't ... That's not good care. She doesn't feel like she's doing a good job.

Michael Akinyele:

I think on a case-by-case basis, and without knowing the details, it's really challenging for me to weigh in on that specific case. But access to care is definitely a significant priority, and working through all of the processes that allow the appropriate care path to be set up and for the patients

to be connected to that, I think, has been a work in progress. It's not unique to the VA, I don't think. We all have our challenges accessing the right levels of care.

Michael Akinyele:

So to that degree the recommendation is, in as much as they can, they should reach out and work with their patient aligned care teams and figure out how to accelerate that progression to either cardiologists within the VA or cardiologists in the Community Care Network, because those are all assets and capabilities that any veteran in the system would have access to.

Ron Barshop:

A happy story is I took a Bible class with a gentleman who was a bomber pilot from World War II, and he had nothing but stellar things to say about the VA for 60 years. He lived in '93. He died a year or two ago, but he was a sweet guy. He was also a super educated health consumer because he was a VP at the Methodist in Houston. So he really knew his stuff when he was going to talk to the doctors, and knew all the games and how to get around those problems.

Ron Barshop:

But he told me something interesting. He said that there's sort of two VAs. There's if you're combat. Meaning, you pulled a trigger, or fired a rifle, or were on the front, or flown an airplane in his case. You got one level of care. But if you were a desk jockey, you didn't always get the same level of care. Those guys had a little bit less of a red carpet. I mean, that was his experience. I don't know if that's true or not. And again, it's maybe unfair to even ask this question.

Michael Akinyele:

No. I think any question's fair. It's fair game. What I will say is that would be news to me. I think every veteran is treated with the utmost respect. There is no signal, at least that I've seen, that indicates one's combat versus not. So I would assume that unless the anecdotal case you referenced, if there's enough evidence that would indicate that combat versus non-combat was the filter for how someone got treated versus someone encountering someone that maybe wasn't having their best day. So that's how I would look at it versus saying there's a separate access point or separate set of experiences for one type of veteran versus the other.

Michael Akinyele:

No, that has not been my experience. I can tell you I have not seen any type of guidance on that, so I would find that very, very strange if it were a thing. But I personally would not be able to indicate that that was a thing, because it definitely wasn't, not from my perspective.

Ron Barshop:

Let's talk about your role as chief innovation officer. You had a budget and you were allowed to tackle some problems. Let's just take a look at the suicide problem. The only group in America that has more suicides on a per capita basis are physicians, particularly primary care physicians. They have a higher suicide rate than veterans. But we're losing, what, several hundred veterans a day? We lose one an hour. Is that what you said? Something like that? You told me a number.

Michael Akinyele:

No. No, no, no, no. The number is, which any number's too high, but it's 17 veterans, out of the latest reports that were issued, commit suicide every day. Out of that number, only about a third actually have interactions with the VA. So we are in a crisis on that regard because we're just not in a position at this point, for a variety of reasons, to have those tangible touch points with every single veteran. And the suicide statistics kind of bear it out in that, A, the number is 17, B, majority of those folks who go through that ultimate process of self harm that leads to death, majority of them are not in contact with or engaging the VA. So opportunities exist across the board to improve on that, but the number is 17 veterans that. You may have heard 20, but that includes reservists and active duty. So why don't we just drill down to the veteran population at 17?

Ron Barshop:

Let's talk about your accomplishments as chief innovation officer. I'm sure you had many that you're proud of and many frustrations that you wish you could have had more budget to deal with. What are some things that you felt you were able to achieve in your tenure there as the first officer?

Michael Akinyele:

Sure. The biggest piece of it ... So the Mission Act passed in 2018. With its passage, it created the Center for Innovation, for Care and Payment, which, in its mission, it's truly looking at how we move the enterprise towards value-based payment. So the process of establishing the center, so a lot of regulations working through the agency, working with OMB, getting that passed and established was definitely a big accomplishment. Definitely didn't do any of that alone. It took a whole agency effort to get us to that point. So two-stage rule making process ultimately put the center and its operating regulations in the books as a permanent fixture.

Michael Akinyele:

The other part that was very rewarding was that there were waiver authorities included in that center. In order to keep those waiver authorities on a permanent basis, we had to get our first proposals submitted to Congress basically 18 months after the law was signed. So that gave us from June 6 of 2018 to basically December 6 of 2019, and we got it done. We got our proposal in. Congress, I'd say, miraculously passed it. The president signed it into law March 3rd. So for me, those were just some pretty monumental things to set something like that up and have those assets available to the agency for decades to come.

Ron Barshop:

And what is the primary mission?

Michael Akinyele:

The primary mission is really around transforming the agency towards a more value-oriented enterprise around, I'd say, do more for veterans and taxpayers. By doing more for veterans, that giving higher quality care. By doing more for taxpayers, that's doing it at a lower cost. So the goal is to create a more sustainable VA that helps more veterans. That's a tricky needle to thread. Because ultimately most enterprises, I'd say VA included, when we do more, usually need a

bigger budget. So the budgets have grown as we've continued to do more. I think ideal scenario would be looking at ways to doing more without exponential growth in budget, because it really gets to sustainability. If you kind of look at how other agency funding has gone, you've really seen a lot of agencies get clamped down on from a budgetary standpoint. I think some stuff like that will continue.

Michael Akinyele:

So the opportunity to just look at how to continue to meet the mission while funding other priorities is going to be the best way to think about a more comprehensive future for the VA, or any agency that's more value oriented. It's really about doing more with as much resources as you have today or potentially less, right? And it ties right into where healthcare overall needs to go. Because healthcare, it costs too much. It's too big a share of our GDP. And it doesn't do well for, I'd say, overall American prosperity because it makes us less competitive if we spend that much on healthcare. It's baked into everything we make domestically. We can talk about this forever, but that's the gist around the primary mission of the center.

Ron Barshop:

I know you believe in Medicare for All called [inaudible 00:15:41]. Let's not call it that. That's [crosstalk 00:15:44].

Michael Akinyele:

No, no, no, no, no, no, no. Don't attribute that to me. I wouldn't say there's any policy out there that I would fully embrace at this point. You can poke holes in everything,

Ron Barshop:

Right. By the time this airs, we'll have probably a new president likely and maybe even a new Senate. Is there a possibility that using the VA as sort of a counter punch is a good example of what not to do? In other words, there's a lot of things we can do to improve the VA, but can any giant bureaucracy truly run healthcare as a federally funded, federally run program?

Michael Akinyele:

I think the model matters. I don't know that I could definitively say yes or no. The challenge is, having been someone who's worked across healthcare, it comes down to trust and motive. A for-profit enterprise is designed to profit, which is the reason why healthcare is so regulated. It's because if left to its own devices, I think with people's lives in the balance, a lot of bad things could happen. I think we saw some of that, which is why things had to be put in place around pre-existing conditions.

Michael Akinyele:

I don't look at any of this with any naivete, right? It's complicated. I don't know that I have the answer, and I don't know that I would rule out the role of a bureaucracy in managing the payment of or delivery of healthcare, even if it's just as a counterbalance to the forces of capitalism being unrestrained. Because that, in as much as I am a free market capitalist type of person, I still have some caution in just not having, I'd call it, the federal bureaucracy involved in healthcare, for good or bad. Because if nothing else, it slows things down so that things can be

thought through properly versus just no-holds-barred healthcare kind of doing its own thing. So that's where I'd land.

Ron Barshop:

Yeah, I know you're a ...

Michael Akinyele:

I don't know enough to be definitive one way or the other.

Ron Barshop:

I understand. You and I share that we love healthcare where everybody wins, a future everybody wins. Let's take the patient's perspective and how COVID-19 has forever changed the patient experience. What is your two-minute overview on how patients are never going to be the same again after this C-19.

Michael Akinyele:

I think in a lot of different ways. I think there is probably a lot more comfort with virtual engagement with care that may not have existed prior to COVID, and that's just been both providers and patients have been forced towards that. So I'd say there's probably a greater comfort with virtual experiences related to healthcare, and I think we're just scratching the surface on what that could be.

Michael Akinyele:

I think the other piece is really thinking through how patients might have been initially dependent, I think, on always engaging their provider, and particularly always engaging their provider inside of their office as the best way to work through issues or figure things out. They might, in this period, have gotten a little bit more comfortable with either just letting certain aches and pains go, or potentially just working through other means to get answers.

Michael Akinyele:

I think fundamentally those two things will change some of the utilization patterns that have been seen historically, and I think it also changes some of the access points. Because if you now have a patient population that's more comfortable with digital experiences around healthcare, and then you have a population of folks who are not going to the ER or urgent care because of every little thing, that could help with utilization over time, and that could also just help with how virtual care scales. Those are things that would not have happened, I don't think, without the push from COVID.

Ron Barshop:

Yeah, here's what we do know. Out of about roughly 450 million patient visits in primary care clinics, 85% of them are obviated by virtual care. In other words, you can get them handled by phone, by secure text, by FaceTime-type HIPAA-compliant applications. So that's right on point.

Ron Barshop:

Let's take the doctor's perspective now. What has changed forever if you're a primary care physician with C-19 in your bag of tricks now?

Michael Akinyele:

I'm assuming most that you're referencing are fee-for-service. So those that survived some of that volatility in income, I think they should, if they haven't already, start thinking through how they diversify some of the revenue sources and how they really start thinking through some of the solution sets that are out there to help with diversification. Otherwise, they're setting themselves up for the next shock to not be prepared for that.

Ron Barshop:

Yeah. Yeah, we've had a lot of value-based care organizations, Catalyst in Dallas, Chris Crow. We've had Clive Fields. He has VillageMD. And we just had ChenMed, who's a full-risk carrier. I'm sort of a fan of the full-risk carrier because their incentives are all in the right place. They are taking all the risks, but they're also getting all the reward if they get those particularly chronic patients down to manageable levels.

Ron Barshop:

Okay, so now we talked about the doctors, let's talk about the perspective of costs. Are costs going to go down with more virtual care visits? Are costs going to go down now with less utilization?

Michael Akinyele:

Depends on the market. I look at it this way. Cost is a function of two things, how much something is priced at and how much of that thing gets used. So when you look at total cost, you need to factor in the power of the market players to change the price. Even if you're in a scenario where the utilization is going down, what power do the players have to change the price? So in as much as price can be changed, costs may or may not go down. Actually, in a lot of markets that are increasingly consolidated, some of the players have the ability to change the prices.

Ron Barshop:

We know that in every metro in America there is a hospital or two that has monopoly pricing power. Maybe not monopoly control, but pricing power. We know that in every state there's one or two insurance companies that have monopoly pricing power. Again, maybe not monopoly control. And with Medicare Advantage, there's companies like Humana who are deeply involved with that, that have pricing control there as well.

Ron Barshop:

Fourth category. Let's talk about what changes forever if you're an employer, because it seems to me that more employers are now going direct contracting. They're going reference-based pricing. They're skipping the middleman. What do you think the employer is going to get out of this C-19 pandemic with the long range?

Michael Akinyele:

That is a group that I think holds more weight than I think they give themselves credit for, because they hold the dollars and they could decide like others to go the self-insured route or self-pay route. But depending on size, they might just be stuck going with what the market offers versus being in a position to make any material change. That's one piece. I think the other piece is employers could decide to be innovative if they have enough density in one particular area. They could also decide to do things like just develop relationships with virtual primary care providers that defray or control how the rest of their network gets used. That's just off of the top of my head, but I think employers could really take a hard look at how they've historically gone about the business of providing health benefits to their employees and actually shake things up a little bit, because I think they have the power to do that.

Michael Akinyele:

I think the other piece is going back to policy land. If the public option becomes a real thing, then that's something employers could just ask their employees to go for. Now, I don't know that they'll do that because part of the give and take of employer benefits is it does create ... I don't want to call it golden handcuffs, because it's not a golden handcuff. But it does create that weight of sorts between the employer and the employee when the employee knows that their health care, which is their network of providers, the providers they have a history with, is connected to their employment. And I think employers also enjoy being in that position.

Michael Akinyele:

So in as much as an employer is willing to let go of that weight, if you will, and allow their employees to have other sources of healthcare, then we could be looking at a whole new future where your source of healthcare is not your employer and is not connected to your employment. That could be very liberating, I think, for a lot of Americans or people in general. I just don't know that employers would be interested in not having that in their toolkit, if you will. That's part of the reason why healthcare is so complicated and quote-unquote fixing healthcare is so hard, because there are all these relationships and co-dependencies on the current complexity that just trying to address one thing without looking at the whole just doesn't really get anywhere because they're just ... There's so much we don't know. There's so much below the surface.

Ron Barshop:

Couple of quick numbers I'll give you from guests from this show. Medici, an Austin-based firm run by Clinton Phillips, 13 million members, virtual primary care. They serve about a third of the Fortune 100. Certainly not all their employees, but 13 million is a pretty decent number. We have Crossover Health. Over a million members taken care of in virtual primary care and onsite clinics at the mostly technology headquarters and fulfillment centers for Amazon. Three million members with 98point6, so that's Robbie Cape. We've had Brad Younggren, the chief medical officer on the show. That's 15 million right there. And then, pardon me, Walmart is now using Centers of Excellence, so they're doing more direct contracting with their two million partners. There is a small movement, but a movement yet nonetheless of thought leaders and employers that are making these switchovers.

Ron Barshop:

Dang it, we've run out of time. There's so much more to talk about with Michael Akinyele. We've got to do another show, Michael. There's no way we're going to let you off with this lousy half-hour, buddy. I mean, I'm sorry, but you're way too interesting. You have too much of an overview for us to let this go. But we do have to let people know how are they going to find you if they want to reach you.

Michael Akinyele:

So if folks want to reach me, easiest way is through my website. It's themaximizergroup.com. That allows you to see a couple of things I'm working on. And also, easiest way to just contact for information is to shoot me an email to set up time to talk or just go through whatever it is they want to do outreach around.

Ron Barshop:

Okay. I love to ask the question, as you know, at the end. You can answer it without me asking it, even. What banner message would you fly overhead if you could give something to all Americans?

Michael Akinyele:

Think big, but act practically.

Ron Barshop:

All right. I can't wait to do this again. Thanks again for your time, Michael. This goes too fast with smart people like you. But we look forward to bringing you back, and I wish you to be safe and smart. I don't need to worry about that either case with you.

Michael Akinyele:

Likewise.

Ron Barshop:

Okay, you take care.

Michael Akinyele:

All right. Take care.

Ron Barshop:

Welcome to just a hospital minute. We are adding these segments for one minute at the end of every show to tell you some of the games that hospitals play.

Ron Barshop:

Patient portals can often be worthless. One of my dear friends who was a CEO of multiple companies recently asked for x-rays for a major system we've all heard of and other reads to be sent to his family doc. What came through week after week were black images. Patient portals can be worthless. So, this is just another hospital minute.

Ron Barshop:
Thanks again. Thanks again to our sponsor, the MediSearch Institute. I want to read you a note a CEO friend of mine sent me who used them for a rare childhood disease her daughter had. Dr. Talbot's research was thorough. He provided clear paths of treatment and he gave me access to the best physicians. I'm so grateful for his work. That's the MediSearch Institute.

Ron Barshop:

Thank you for listening. You want to shake things up? There's two things you can do for us. One, go to primarycarecures.com for show notes and links to our guests. And number two, help us spotlight what's working in primary care by listening on iTunes or wherever you get your podcast and subscribing and leave us a review. It helps our megaphone more than you know. Until next episode.