Primary Care Cures
Episode 113: Thompson Aderinkomi

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:

Primary care is in the name of this show. And why do we even care about primary care? Well, why we should all care? Let me start off with a couple of paraphrasing quotes by two of the largest PCP groups in the country. Optum care is the largest by far, they have over 46,000 doctors in their group, that's a division of UnitedHealth. And Sir Andrew Witty who was the president of UnitedHealth and CEO of Optum, before he left to work on a COVID project, had a quote that said, "If you invest 5% in primary care up front, you save 95% downstream," something our guest understands very well today.

Ron Barshop:

On the same day he came out, Gregory Adams who was alive then, he passed since then, but he was the head of Kaiser Permanente, the second largest primary care group out of California, and he basically said that, "We were able to save $5 billion for our members last year that we refunded in the form of dividends," which is just unheard of with a plan. And of course they're a hospital and a plan and a group, they're integrated, but he also reiterated the importance of primary care. It Was the reason why they were able to save that kind of money, with an intense focus on primary care with his exact quote.

Ron Barshop:

So the two largest primary care groups both agree, it's a great investment, but let's go a little deeper into that. So not only is primary care important because it's the mouth of the Nile of healthcare, it's where all referrals or most referrals start for most of the system. So it's a feeder, and that's why all of these large hospitals and large insurance companies are buying primary care groups, it's because they want they want the meat to feed the grinder. Also a higher ratio of primary care physicians in a population is almost always going to be associated with lower mortality rates for all causes, and from heart disease and cancer in particular. And having more specialists in an area does not decrease the overall mortality rate or deaths from cancer and heart disease, but more PCPs do.

Ron Barshop:

In States, whether there's higher percentage of physicians that are PCPs, they always had the higher quality care and lower cost per beneficiary in many, many studies. And this factor alone accounted for nearly half of the variation in Medicare spending from one state to another. So lots of docs that are primary care is great for cost to Medicare. And having a PCP for life is like quitting smoking or wearing a seatbelt in added years. So we all know to wear seatbelts, we all know not to smoke, and having a PCP is right up there.

Ron Barshop:

And more importantly, let's talk about the bottom line for employers because that's where guest today is, taking care of the employees of employers in the Minneapolis, Milwaukee, and larger region. The bottom line for employers who contract direct with primary care is a very real. Hospital stays dropped 30%, ER visits cut in half, radiology and other testing drops 65%, specialist visits dropped 62%, and surgery drops 80 whopping percent. So just because there's less complexity as our CEO of Optum, as our CEO of Kaiser said, there is less utilization.

Ron Barshop:

And chronic disease drives 80 to 90% of all the costs of healthcare. So some studies show that an intensive primary care can manage that and even reverse it, we've had guests on here that have, like Jean Kessler. In addition, primary care physicians strive to understand the whole patient, so it's not episodic or transactional as they say. A surgery is a transactional procedure, an urgent care clinic and ER visit, those are all procedural or transactional, I should say. A test, a birth, a visit to any other sort of specialists, it's a once or two-off thing. You're not going to go as a constant regular visit. And so this is all intuitive stuff, but here's... What's not intuitive is my own experience with direct primary care with Redirect Health, who's been a guest on our show many times.

Ron Barshop:

Our own turnover rate, in my company, is essentially zero, so people that have access to free primary care don't want to leave. They like that instead of going to a Medicaid clinic and waiting forever, and dealing with a hacking and the coughing and all of the time [stack 00:04:09] that's involved with going to see a doctor in the Medicaid system. Now, they can just get on the phone, text somebody, talk to somebody, FaceTime in a secure manner with somebody and have access to a doctor or a nurse, so we find better people faster. It used to take me 60 people to find one good MA. And now I can, in four interviews, find four good people, and that's not a joke. So when you have an offering of free access to primary care, like our guest today, that makes all the difference as an employer.

Ron Barshop:

I can't wait to talk today to Thompson Aderinkomi, and he's currently the co-founder and CEO of Nice Healthcare. Just like it sounds, it's a technology-enabled primary care clinic that delivers all the care in the comfort of the patient's home or phone, and contract directly with small employers in the Minneapolis, Milwaukee or, again, surrounding areas much larger than that. He's also a co-founded before that at Retrace Health in 2013, which was a DPC medical practice that went on to raise over $7 million. So Thompson, welcome to the show.

Thompson Aderinkomi:

Thank you. Happy to be here.

Ron Barshop:

Well, so as you can tell, I'm a big fan of what you're doing, without you even uttering a word. But tell us a little bit more about what you're doing and how it works.

Thompson Aderinkomi:

Certainly. So first, let me start with what we do, and then I'll tell you about who we do it for. So what we do is we are a full-service primary care clinic. We work with nurse practitioners and physician's assistants. They're all employees, so we're not taking the cheap way out and contracting out these services. They're well paid employees with full benefits that have time to care for their patients. And the way we care for our patients is through a combination of virtual care and in-home care. So for us, every visit starts within our app as a chat visit or a video visit, and in the events that we need to do hands-on care, we deploy one of our own medical providers to the patient's home, typically the same day within an hour or two. And in the home, we're doing things like x-rays, physical exams. Sometimes we're delivering prescriptions, we're doing labs and tests. We've recently added virtual physical therapy, we're talking about adding mental health services.

Thompson Aderinkomi:

And the key point here, as you've alluded to, is that all of these services are free to our patients. They don't have to worry about the cost of labs and tests and x-rays and images, or the cost of a home visit or the virtual visit. They don't have to get worried about getting upcharge from the transition, from a virtual visit to a home visit. And the way we make it free to our patients is by focusing on small employers. So let me define small employer as employers with fewer than 1000 employees. Now, our median-sized client has 44 employees, with the smallest having five employees, the largest having a little over 1000. So we can serve any patient, any client, any size.

Thompson Aderinkomi:

And we are fully transparent, this is something we're very proud of. You can go on our website right now and see how much our service costs per employee. And the cost right now is between $30 and $36 per employee per month. So $30 to $36 per employee per month, the dependents are completely free, it doesn't matter how many dependents they are. And the employee and their dependents get unlimited access to all of our services without any co-pays, except, unfortunately, in the case of an HSA, there is a small fee due to IRS regulations. We're not going to get into that today.

Ron Barshop:

Okay. So if I have a family of 10 screaming kids, you're going to take care of all of my kids and my wife for $36 a month.

Thompson Aderinkomi:

Absolutely.

Ron Barshop:

Wow. Okay. That's really quite an honor. I mean, not an honor, but it's a departure from anything I've heard before. All right. So let's talk about x-ray because that's confusing me. You can't exactly carry an x-ray on your backpack and bring it into a home, how in the heck do you do that?

Thompson Aderinkomi:

Yeah. We use portable x-ray machines that can fit inside a Toyota Prius with the seat folded down. They're light enough for one person to carry. I've had it done in my house multiple times, it's very easy. And we work with partners across the country to augment our services, to make that service available for free to our patients.

Ron Barshop:

Wow. Okay. You also do labs. I'm sure it's not unlimited labs. What types of labs are you doing in the home?

Thompson Aderinkomi:

Yeah. So I'll talk about labs and prescriptions together. So we're doing the basic panel of labs. So we've found that the labs that we provide cover about 80% of the labs that are typically conducted in a primary care setting, that's why 80% of the labs are done at no cost to the patient. And then for prescriptions, we include over 550 different prescription drugs in our program, again, at no cost to the patient. They can pick up those drugs for free at their local pharmacy using the pharmacy benefit that's attached to our program.

Ron Barshop:

So the employer is paying for the pharmacy, not the employee.

Thompson Aderinkomi:

The pharmacy is included within that PEPM, that $30 to $36.

Ron Barshop:

[Right 00:08:58]. Okay. You're confusing me. You're telling me that you're offering 550 meds for no cost to the employer or the employee?

Thompson Aderinkomi:

Correct.

Ron Barshop:

Oh, okay. It's good. You're blowing my mind one sentence at a time here. Okay. Well, that's pretty wonderful and unusual, too. I've not heard of that. And then you're also offering, it looks like, I was reading your website, blood draws, x-rays, labs and, of course, exams. So you're going to do a woman's well-check for the wife, you're going to do the male check, you're going to do the children's pediatric, that person could be there all day, I mean, for a large family.

Thompson Aderinkomi:

For a large family, it's simply... They're not scheduling those types of visits on the same day because it'd be disruptive to their own life as well, to have these really long visits. But we do have some restrictions in what we do. So we do not do pelvic exams for safety reasons, maybe we will in the future. So we're not doing a women's pelvic exam or a men's pelvic exam, but we do all of the components of the wellness exam, and we do not prescribe controlled substances. So we're not prescribing any of those controlled substances at all, whether they're part of our program or not.

Ron Barshop:

So let's talk about the urgent care procedures. Are you setting sprained ankles, are you... What other types of typical things you'll see in a PCP office for they have all kinds of resources in their storage closet? What can you and can't you not do in a home?

Thompson Aderinkomi:

Yeah. And this gets to our theory about the disintermediation of primary care. Primary care is really just lumped into one building with one doc, and it really needs to be segmented out based on the use case of the patient. So for us, we are not an urgent care or an ER, so the general rule of thumb we give our patients is, "If you can't wait an hour, then you should go to the urgent care or the ER," because we are a primary care clinic, and so we can't attend to those urgent or life-threatening or very uncomfortable situations. So we're not setting broken bones, we're not putting in stitches, we're not taking care of massive bleeding, things of that nature. We are a primary care clinic and our mission is to establish a relationship because as you said, it's that ongoing relationship with a primary care clinician that's going to lead to better health outcomes and lower costs.

Ron Barshop:

Okay. So I mean, just as a ridiculous example, but while you're there doing a woman's well-check, not a pelvic exam but a women's well-check that you can do, the kid cracks his head open on the coffee table. Can you not treat that while the doctors or the nurse is right there?

Thompson Aderinkomi:

I mean, if we have what it takes, what's needed, if we were ready there, theoretically, yes, we could treat it. But if we don't have the proper equipment and supplies, we wouldn't be able to treat it.

Ron Barshop:

Okay. So it's a ridiculous question because I'm sure it happens every blue moon. And I'm going to assume by your tone, and what you're saying that you're going to be adding services all the time, drugs all the time, procedures all the time, your care stack is going to be growing, I assume.

Thompson Aderinkomi:

Absolutely. This is something that we talked about internally. I just said at our all-hands meeting this morning, where we are seeking to make the value proposition for Nice Healthcare so insane

that it becomes morally questionable to turn us away if offered the opportunity to have us provide services to employees. So our case in point, when we launched, we did not have a pharmacy benefit as part of our program, we did not have unlimited physical therapy, we did not have mental health services. We didn't have these things in some of the markets that we've launched. We're operating in Utah, Arizona, Wisconsin, Nebraska. Sometimes we launch a new market without the imaging component so, really, we are just seeking to add as many services as possible. And when we do add them, we are not increasing the price of our service to our clients, we are just that good. We've built a skill set of efficient operations that allows us to pass on the savings to our clients and their employees and their dependents.

Ron Barshop:

Okay. So let's talk about physical medicine because that's a giant subject. So many people have bad backs, so many have bad posture, and they've got knees, ankles, hips, shoulders, what is your provider able to do in the home? Or do they need to come to a physical chiropractor's office or a physical therapist office once that diagnosis is made? How does that all work?

Thompson Aderinkomi:

Yeah. Unless there's some specialized equipment that's needed, we can do whatever you could do in a clinic, in the home, for these musculoskeletal issues. Now, most of them are handled virtually. It's amazing what you can do virtually. And more important, we believe that actually having all the equipment, having the right location is actually just making it easy for a patient to do the visit. So many people put these things off, they avoid them, they get a referral, they don't follow up because it's inconvenient to go. It's time consuming or it's expensive. So that really is the first barrier, that's the barrier that we're focusing on, it's actually just get people access first and foremost, and that can lead to incredible health outcomes and savings much more than having the exact piece of equipment that you'll need.

Ron Barshop:

You're a new offering. So have you had time to calculate those savings, or is that something downstream we should talk to you about?

Thompson Aderinkomi:

You know what? So I'm a statistician by training, I went to graduate school in statistics, and I used to do that as a health economist all day. And if you want to see a study that shows you savings, I can produce it. And if you want to see when it does not show savings, I can also produce that same data set. So what I tell our clients is, "Look, there's no funny business here. When I started this company, I started from a statistician's point of view which is, 'You could see the value without doing an ROI study.'" And that is just plain and simple, what's happening. And this is the case in point, I always have to back up what I say with evidence, so that you know what I'm saying is true.

Thompson Aderinkomi:

So we operate in five different States. In every market, multiple carriers are offering a premium credit to fully-insured employers that put our service in place. We did not give these carriers data. And we're talking to all of the major carriers, the regional carriers, many of them, we gave a

list of the services we provide to their actuaries, and their actuaries all calculated a discount on their premium. And they've all calculated a discount on their premium between 2% and 4% of total medical spend for a fully-insured employer that puts our service in place. So that is really what health innovators need to be doing. You don't need an ROI to know if something is saving money, saving time, leading to better outcomes. It should be evident from the get-go, and we're one of the only solutions that is.

Ron Barshop:

2% to 4% is ridiculously low, I mean.

Thompson Aderinkomi:

Oh yeah. I mean, they're still ripping us off, the client and me. But it's a start, and we'll continue to push on that 4% year after year. We'll be able to justify why they need to share more of that savings with the client. We're estimating that's at least 10% minimum.

Ron Barshop:

Oh, at least. So, okay. So now I'm understanding better. So an employer with 44 to 1000, let's say, employees is going to engage you. They're going to pay an extra 36 bucks a month, they're going to continue paying the $15,000 or $12,000 premium per employee. The employee still has their premium, they have to pay for the employer, right? I mean, that doesn't go away.

Thompson Aderinkomi:

Correct.

Ron Barshop:

Okay. So this is an add-on. What resistance are you getting, selling, basically, frictionless healthcare? Because that's what you're selling.

Thompson Aderinkomi:

Yep, exactly, frictionless healthcare. The only resistance we get is when there's entrenched interests at play. Literally, that's the only time. So suppose there's an onsite clinic that's sponsored or run by the local health system, they're charging three, four or five times what we would charge. Oftentimes it's nearly impossible. Actually, it's been impossible every single time to beat them out because of the entrenched interests, the connections, the politics, things of that nature. With the large employers like the Taco Enterprise so, let's say, employers with 5,000 or more employees, what their resistance is they don't like the fact that we don't operate in every state and in every city. But for some reason, they have no problem putting an onsite clinic at headquarters so, again, I say entrenched interests.

Thompson Aderinkomi:

And then of course, the health systems with a strong primary care, mouth of the Nile, I really liked that analogy that you used there. If there's a large mouth of the Nile primary care-based health system, they do not support what we're doing because we are not tethered to any insurance

company. We are not tethered to any health system, so we refer to the best place for the patient, not based on who we're affiliated with, and that's a threat to health systems.

Ron Barshop:

Okay, so when it is... Let's talk about a referral. Now, it's time to make a referral because somebody's going to have a baby or somebody's... Whatever, they're going to need a surgery, they're going to need to go for some kind of radiology you don't offer. How do you make that referral?

Thompson Aderinkomi:

So that referral happens the same way it would in a traditional clinic. So in that regards, we are not much different. Now, we do use a service called RubiconMD, it's a great service and software application that helps us optimize those referrals to ensure that they're needed and that they'll be productive once they're referred. So as soon that we've already verified that the referral is truly needed, since we don't benefit because we're not in a system, from referring, then the clinicians are referring based on their own local knowledge and their own research with other clinicians, on where the best place is to refer a patient for a specialist visit.

Ron Barshop:

Yeah. Jay Parkinson with Crossover uses them as well. And we had them as guests on our show, both the two founders. So yeah, they're a great resource, it sounds like, for a lot of companies like you.

Thompson Aderinkomi:

Yep.

Ron Barshop:

So what are your plans for the next three to five years? What do you think you're going to look like in terms of number of patients, and what are you going to look like in terms of a number of employers and physicians you'll have on board? What is your long-term outlook?

Thompson Aderinkomi:

Yeah. So in the next three years, we estimate that we'll have approximately 150 to 200 clinicians on board. We'll be operating in approximately 20 different States, most likely 30 different markets across those 20 different States. And our membership, if you're talking about employees plus dependents, we'll be close to 200,000, 250,000.

Ron Barshop:

Okay. So you're getting started now, but you've already got some traction, so that's wonderful.

Thompson Aderinkomi:

Yeah.

Ron Barshop:

Wow. Okay. Well, very unusual offering and, I guess, there's some way to make money like this. Do you have a ratio of providers to patients that makes sense? Do you try to keep it to some magic numbers so that you're not overburdening your team?

Thompson Aderinkomi:

Yeah. There is a magic number in order to maintain the profitability measures that we've set out to achieve, and that number is about 800 to 1,000 members per full-time clinician.

Ron Barshop:

Very nice. Okay. And I'm also going to assume you're hiring mostly nurses and PAs?

Thompson Aderinkomi:

Yep, nurse practitioners and PAs.

Ron Barshop:

Okay, and then... All right. Well, I think I've got all my questions answered. Is there something I didn't ask that I should have asked?

Thompson Aderinkomi:

No. I mean, these are great questions. And someone like you who's in the industry knows the right questions, so we've covered quite a bit in a short period of time.

Ron Barshop:

Well, look, I love what you're doing. I celebrate new primary care models like this. People love to poo-poo anything that's not Dr. Kildare in a hospital, or Dr. Marcus Welby in his clinic. I mean, they're used to this model that you got to do it a way, and primary care is such a flexible rubber band these days. There's so many interesting models out there, and you have certainly pioneered a new one, for sure. So isn't it just remarkable how intuitive all this is and how complicated people like to make it?

Thompson Aderinkomi:

You wouldn't believe, when I set out to start this company with my co-founders, people thought we were crazy because they thought it would be too difficult. But I would try to tell people, "Look, the bar is quite low for improving primary care. And if you untether yourself from insurance companies and health systems, it becomes quite easy. You can literally do anything you want for the patient to keep them healthy and save them money." And so a by-product of this is that we are one of the most popular and sought-after places for clinicians to work in primary care. There's no better place to work because you don't have all that overhead, you don't have all that regulation, you don't have all those administrators [breathing on your neck 00:21:33]

Ron Barshop:

That just seems so intuitive, but here's... The part that's not intuitive is that it's not efficient to get in a car and go drive somewhere that's out in the middle of nowhere. I mean, I'm sure you're

treating in Minneapolis to Milwaukee, the suburbs, the outlying areas within a certain driving radius, but you can't treat all of Minnesota and all of Wisconsin from those two cities.

Thompson Aderinkomi:

Yeah. I mean, the way our launch strategy works is when we launch a new market, say we're in Utah and Arizona right now, we start off in the city. So in Utah, we start off in Salt Lake city. Arizona, it's the Phoenix area. So we start there the first year, then we expand. So when you look at our trajectory, you can look at what happened in Minnesota. We started off in Minneapolis and St. Paul, but today, three years later, we cover 16,000 square miles of Minnesota. It's a huge area, over 30 different counties, and those 16,000 square miles include 77% of Minnesota's population. So what we do is we just keep on pushing out because when you smartly couple virtual care with in-home care, what you do is you basically make up for the inefficiency of driving with virtual care, and you can still provide that great transparent price point to the client on top of all the additional services that we provide at no additional charge.

Ron Barshop:

So I'm smiling while I ask this question, but you have to have been surprised when Nice Healthcare was available as a website. I mean, it's so like, "Who wants to be in Nice Healthcare?" Nobody thinks about that, is Nice going with healthcare.

Thompson Aderinkomi:

It doesn't. And you know what, you want to laugh some more. I also bought the domain Nice Health insurance, it was $20. I mean-

Ron Barshop:

Well, they don't go together, that's why. It's like saying warm ice, warm snow cones. I mean, it's just, "Nice? That doesn't fit." Well, you are definitely a face to watch. I know the governor of Wisconsin is watching you and involving you in the larger healthcare picture. And keep up the good fight, man. We're all on your side and supporting what you're doing. And I hope you grow to all 50 States and beyond.

Thompson Aderinkomi:

Thank you. Appreciate that, honored to be on the program.

Ron Barshop:

Yeah. I've got to ask you two more questions. If people want to reach out to you, Thompson, how do they find you?

Thompson Aderinkomi:

LinkedIn and Twitter, that's where I hang out. And so I'm very easy to find and I reply to every message, unless you're trying to sell me something. And yeah, I'll get back to you if you reach out.

Ron Barshop:

Oh boy, and they're all trying to sell us something. And then the other question is, "If you can fly a banner over America, not just Milwaukee and Wisconsin and Minnesota and Utah and Arizona, what would that banner say to all Americans?"

Thompson Aderinkomi:

I would say, "Don't give up hope, play your part in making things better."

Ron Barshop:

Oh, that's nice. I love how you opened in your LinkedIn, by the way. I think you say, "I have a new way, a new offering." What is that, that you say in your heading-

Thompson Aderinkomi:

Oh, "I'm the bearer of something new."

Ron Barshop:

"I'm the bearer or something new," that's just so beautiful. Anyway, glad to have you on the show. We're going to be watching you closely and excited to follow your progress.

Thompson Aderinkomi:

Thank you. Thanks for helping to share our story.

Ron Barshop:

Thank you, Thompson.

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.