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Workplace Clinics: A Sign of Growing Employer Interest in Wellness

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Interest in workplace clinics has intensified in recent years, with employers moving well beyond traditional niches of occupational health and minor acute care to offering clinics that provide a full range of wellness and primary care services. Employers view workplace clinics as a tool to contain medical costs, boost productivity and enhance companies' reputations as employers of choice. The potential for clinics to transform primary care delivery through the trusted clinician model holds promise, according to experts interviewed for a new qualitative research study from the Center for Studying Health System Change (HSC). Achieving that model is dependent on gaining employee trust in the clinic, as well as the ability to recruit and retain clinicians with the right qualities—a particular challenge in communities with provider shortages. Even when clinic operations are outsourced to vendors, initial employer involvement—including the identification of the appropriate scope and scale of clinic services—and sustained employer attention over time are critical to clinic success. Measuring the impact of clinics is difficult, and credible evidence on return on investment (ROI) varies widely, with very high ROI claims made by some vendors lacking credibility. While well-designed, well-implemented workplace clinics are likely to achieve positive returns over the long term, expecting clinics to be a game changer in bending the overall health care cost curve may be unrealistic.

Growing Employer Demand for Workplace Clinics

With employers facing relentless growth in health care spending, demand for workplace health clinics has increased over the past five years, according to most industry experts interviewed by HSC researchers (see Data Source). Even during the recent recession, employer interest remained high, although some chose to delay implementation or scale back clinic plans until economic conditions improve.

Workplace clinics are not a new phenomenon. Until the 1980s, it was common for large employers to operate onsite company clinics to treat work-related injuries. Many clinics closed because of declining heavy industry and manufacturing sectors and workplace hazards becoming less common in these sectors. Apart from occupational clinics, other early adopters of workplace clinics focused on providing care for minor acute conditions. These employers—including many in the financial sector—tended to provide clinics as a perk for high-wage employees and to minimize employees' time away from work.

The recent resurgence of workplace clinics has differed markedly from the first iteration of clinics. The focus has shifted largely to health promotion, wellness and an array of primary care services, rather than occupational health or convenience care. Indeed, the increased interest in onsite clinics is

linked to greater demand for workplace wellness programs—an interest shared by both employers and policy makers. The recently enacted health care reform law—the Patient Protection and Affordable Care Act (PPACA)—includes provisions that may encourage more employers to offer wellness programs.

By far the strongest motivation for implementing workplace clinics is to contain direct medical costs. In the short term, exerting greater control over direct costs, such as specialist visits, non-generic prescriptions, emergency department (ED) visits and avoidable hospitalizations, is a key employer objective. In the long run, improving population health by preventing and managing chronic conditions is a major objective. Employers also view onsite clinics as a way to boost productivity, reduce absenteeism, and prevent disability claims and work-related injuries. Some employers implementing primary care clinics also see opportunities to improve access to and quality of care. Finally, some employers view workplace clinics as an important benefit that helps to attract and retain competitive workforces, while enhancing their own reputations as "employers of choice" in their industries and communities.

Large, self-insured employers—particularly with low worker turnover and high worker concentration at worksites—have been most likely to undertake or expand workplace clinics, reflecting that these employers are more likely to reap savings. Some experts reported seeing high interest among smaller employers, but these firms typically find it much more difficult to shoulder the initial capital investment or ongoing operational costs, unless the firm either sponsors a part-time clinic or partners with other employers to operate a so-called "near-site" clinic.

Estimates of clinic prevalence vary, with some recent employer surveys indicating that more than one-third of large employers offer onsite or near-site clinics, while another survey reported one-fifth of large employers doing so.[1] According to HSC's 2007 Health Tracking Household Survey, 8 percent of American families had at least one family member who had ever used a workplace clinic, and 4 percent had a family member who had used a clinic in the past year.[2]

This Research Brief examines the potential of workplace clinics to improve health and contain costs. In addressing these issues, the study first provides context by describing current models of workplace clinic management, services and staffing, focusing on the primary care delivery model that experts view as having the most potential for improving health and curbing costs. Then key challenges—including regulatory requirements—faced by employers and clinic managers are discussed, along with evidence on both direct and indirect returns on investment. Finally, policy implications are reviewed—including the potential impact of clinic growth on community-based primary care and the appropriate role for government, if any, in encouraging the growth of workplace clinics.

Data Source

In addition to performing literature reviews, HSC researchers conducted more than 35 telephone interviews with workplace clinic industry experts and representatives of benefits consulting firms, clinic vendors and employers sponsoring onsite clinics. Interviews were conducted by two-person research teams between February 2010 and July 2010. A semi-structured interview protocol was used in conducting each interview, and notes were transcribed and jointly reviewed for quality and validation purposes. The interview responses were coded and analyzed using Atlas.ti, a qualitative software tool.

Clinic Management Models

Employers considering workplace clinics have three options:

- hiring third-party vendors to operate a clinic;
- employing all clinic staff and management; or
- contracting with external health care providers to manage and/or staff the clinic.

Most employers outsource clinic operations to vendors that provide comprehensive staffing and management—so-called turnkey operations. As one benefits consultant said, "More and more employers are choosing to outsource because running clinics is far afield from their core competency." Many employers would rather contract with vendors that have expertise in everything from employee data confidentiality to medical malpractice insurance to biomedical waste disposal. While most employers contract with vendors focused solely on operating clinics, health insurers also are interested in the business. For example, CIGNA's onsite health division operated 22 clinics for employers as of late 2010. Other insurers offer a more limited onsite presence—often involving biometric screening, health coaching and disease management—but several are considering offering a broader set of clinic services.

The direct employment model—much less prevalent today than outsourcing to vendors—is used more often by employers with longstanding clinics, in part because "fewer clinic vendors were around when these clinics were started, so [employers]

had to build and staff their own facilities," according to one expert. Boeing and Quad/Graphics are examples of companies that built highly regarded full-service clinics using the in-house approach. In addition, some employers—such as the Dow Chemical Company—have developed more limited in-house clinics with an almost exclusive focus on wellness programs.

A few employers that developed their own workplace clinics became so proficient that they launched clinic businesses. One example, QuadMed, which started as the in-house clinic manager for the printing company Quad/Graphics, now operates primary care clinics for other large employers. Similarly, the Cerner Corp., a health information technology firm, first established a clinic at its Kansas City campus in 2006 and then expanded its onsite-clinic subsidiary, Health*e* Solutions, to provide clinic services for other large employers, including Cisco Systems and Kia Motors.

While direct contracting with health providers is relatively uncommon, experts noted that employers sometimes choose this model if they expect or experience opposition from the local provider community to establishing a workplace clinic. In addition, employers with worksites in small, rural communities sometimes contract with local providers because there are limited existing managed care networks. Perdue Farms, the poultry company with rural and small-town facilities in 15 states, is one example. The company negotiated preferred provider agreements directly with physicians and other providers in many communities; when these providers practice at a Perdue onsite health center, it is an extension of their private practices.[3]

Employers with multiple locations can vary models by worksite. Connecticut-based Pitney Bowes, for example, directly employs clinicians at its Connecticut facilities, where the corporate medical director provides oversight. For a facility in a small Wisconsin community, where there was concern about provider resistance, Pitney Bowes contracted with local providers to staff the clinic. And, at locations too far from corporate headquarters for easy oversight, the company chose to outsource clinic operations to a vendor.

Whatever model an employer chooses, experts stressed that clinics are likely to succeed only if the employer remains engaged in clinic oversight. A benefits consultant observed, "There is no such thing as a completely turnkey operation." Likewise, a clinic vendor said, "If we don't have really strong management support [from the employer], there's no sense in going for it. It will be a failure."

Types of Clinic Services

While experts had many different ways of describing and classifying clinic services, the following categories generally capture the range of services at workplace clinics:

- Occupational health—treatment of work-related injuries, employment physicals and screenings, travel medicine, and compliance with federal workplace safety regulations.
- Acute care—ranging from low-acuity episodic care, such as sore throats or sprains, to treatment of more severe symptoms requiring urgent attention, such as exacerbations of chronic conditions.
- Preventive care—physical exams, immunizations and screenings.
- Wellness—health risk assessment follow up, biometric screenings, health coaching, lifestyle management programs and educational programs.
- Disease management—ongoing care for and management of chronic conditions.

Employers can choose different combinations of these services, such as a "wellness model," which typically includes wellness, preventive care and often disease manage-

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ment, or a "primary care model," which typically includes acute care, preventive care, disease management and some or all aspects of wellness. Experts noted that there is substantial overlap among categories. As one clinic vendor observed, "Wellness programming for individuals with high-risk factors and chronic conditions…is essentially the same as disease management, or at least the intersection between those two things should be seamless."

Occupational health is still the most prevalent service provided by workplace clinics, but neither occupational health nor minor acute care is where clinic growth or employer demand is currently concentrated. Instead, demand in recent years has focused on wellness, prevention and disease management. One clinic vendor observed, "Of all the RFPs [requests for proposals] that have come to us in the past 24 months, I can't recall one that didn't ask for wellness and health promotion." Another clinic vendor stressed that onsite wellness and disease management are key to cost savings: "Twenty-five percent of health care spending for employers is specifically for cardiovascular disease and diabetes. If we can attack that part of the dollar, [it is worth treating] 20 runny noses as a way to start a conversation [with the employer] about how to manage those diseases, but if the employer doesn't want chronic condition management, they will never save money treating runny noses."

Experts also noted that more and more employers are using workplace clinics to operate wellness programs because of growing recognition that face-to-face wellness activities—in particular, health coaching and lifestyle management programs—generally are more effective than alternatives, such as Web-based and telephonic coaching. "When it's just a disembodied voice on a phone line in place of a face-to-face session, it's not nearly as likely that [the employee] will form a connection with the health coach, or that the coach can figure out what makes [the employee] tick and what will drive behavior change that's meaningful and lasting," a benefits consultant said.

Clinic Primary Care Delivery Model

Employers increasingly are offering primary care at workplace clinics well beyond basic preventive services or diagnosis and treatment of simple ailments. While the availability of simple, routine care at work can be a valued perk for employees, most experts observed that its direct cost-saving potential for employers is limited, if it exists at all. Instead, these experts noted that what generates savings for employers is the ability to change practice patterns, such as drug prescribing, ordering of tests and procedures, and specialist referrals, along with the potential for early diagnosis and treatment to avoid ED visits, hospitalizations and other costly downstream complications.

Beyond a convenient onsite location, workplace clinics aim to transform primary care delivery in several key ways. First, clinic vendors and benefits consultants noted that—in contrast to most community-based primary care—the typical workplace clinic model offers much shorter appointment and in-office wait times and much longer clinician-patient encounters. For example, some clinics set goals of accommodating patient requests for visits within 24 hours, limiting clinic wait times to five minutes at most, and providing visits with clinicians lasting from half an hour to an hour.

Experts said that longer clinic visits allow the clinician—sometimes, but not always, a physician—to listen to patients, diagnose their conditions and discuss different treatment options with them. In addition, the clinician has time to screen for other problems unrelated to the immediate visit. As a clinic medical director observed, "[During the visit,] our doctors always go

through a minimum health risk assessment, preventive care, blood work…They ask 'How's your heart?' even if you came in for a sore knee…It's a holistic approach, not just acute, episodic care."

Many experts observed that most workplace clinics aim to achieve a "trusted clinician" primary care model, which one respondent described as "having the ability to bond with patients, to build a trusted adviser relationship…[a clinician who] can provide compassion, be accessible, and also be very good at motivating employees to do the right thing."

Respondents noted that the use of evidence-based guidelines and electronic medical records (EMRs) is more common at workplace clinics than a typical primary care practice in many communities. The clinic company Comprehensive Health Services (CHS), for example, uses a set of 300 evidence-based guidelines spanning the domains of acute, preventive, chronic and occupational health. Other clinic vendors and employers described a similar approach, and one corporate medical director noted the sharp contrast between the evidence-based practices at his company's workplace clinics and the primary care practices in the "surrounding small-town and rural communities, where solo and small practices are very much still the norm."

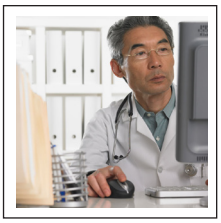
Respondents agreed that the use of EMRs, which is nearly universal among major clinic companies, contributes to internal care coordination, quality and cost containment. However, because of the low EMR penetration in many communities where clinics operate, experts noted that few opportunities exist to use EMRs to communicate with clinic patients' regular physicians. Even when community physicians use EMRs, interoperability challenges mean that exchanging patient clinical data is rarely, if ever, done electronically.

Nonetheless, experts emphasized that clinic staff typically seek to coordinate care with patients' existing providers on an informal, case-by-case basis. The method and extent of communication depends largely on patient preferences. The onsite clinician might provide copies of records for patients to take to their next appointment, have the patient sign a release form so that clinic staff can transmit information directly by fax or other means, or call and speak with the usual provider. Several respondents highlighted the value of communicating with community providers, for instance, to assist patients coping with chronic conditions. One clinic vendor remarked, "If we [clinic staff] are managing hypertension and [the patient is] not compliant…[we] pick up the phone and say, 'We have your patient, her blood pressure is up, her weight is up and she is still smoking. We're concerned; you're concerned. How can we work together on this patient?'"

When patients need referrals to specialists or other providers not available within the clinic, referral processes and networks vary widely across clinics. A few employers, such as Toyota, and clinic companies, such as CHS, have developed "high-performance networks" by using data from such sources as Ingenix and Medstat, sometimes supplemented by the employer's own claims data, to identify physicians and hospitals with better outcomes and lower costs. Most clinics, however, use a more informal, ad hoc approach—relying on clinic medical staff to recommend "physicians they're familiar with from the community that they know are good…It's a more anecdotal approach…It's a stretch to call it a high-performance network, although some vendors that use this informal referral network will label it as such," according to one benefits consultant.

Employee Financial Incentives for Clinic Use

Most employers offering primary care at their clinics choose to supplement rather



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than replace primary care provided in the community. However, a few employers have been more aggressive in attempting to substitute the clinic for community-based primary care altogether—an approach that is used primarily when worksites are located in smaller communities with quality issues, provider shortages or both. When employers aim to replace community-based care, they tend to use health benefit design to strongly incentivize clinic use.

For example, Quad/Graphics employees who use QuadMed clinics for their primary care pay $7 for any service at the clinic and $30 for visits to in-network specialists, after a $150 deductible. In contrast, employees pay 25 percent coinsurance after a $400 deductible for a community-based visit to an in-network provider, or 35 percent coinsurance after a $500 deductible to an out-of-network provider.[4] Partly as a result of this sharp cost-sharing contrast, more than four in five primary care visits by Quad/Graphics' Wisconsin employees take place in onsite clinics. Another employer seeking to replace community-based primary care is Glatfelter, a paper company with a workplace clinic in Ohio. Three years ago, the company introduced a premium-sharing discount for employees who choose the onsite clinic as their primary care provider. For employees with family coverage, annual savings in premium contributions amount to $1,000. As a result, more than half of employees have chosen the clinic as their regular primary care provider.[5]

Among the majority of employers seeking to supplement rather than replace community-based care, a wide variety of cost-sharing arrangements apply for clinic visits. Many employers waive copayments altogether—an approach endorsed by many clinic vendors because it provides a strong incentive to use the clinic. However, some benefits consultants and at least one major vendor expressed reservations about this approach, arguing that consumers are less likely to value services provided entirely for free and that lack of any cost sharing might "induce frivolous demand." Many other employers reduce copayments for clinic visits compared to those charged for community-based visits—$10 or $15 differentials are common. Some employers also provide generic medications for free if the prescription is filled through the clinic. Few employers offer no financial incentives at all to use clinics.

Staffing and Recruiting

Staffing arrangements at workplace clinics vary widely and are dictated by the types and mix of services the clinic provides. Clinics focused exclusively on wellness tend to have health coaches and other professionals with varied backgrounds, such as nurses, health educators, nutritionists and exercise physiologists. In general, the greater the extent of primary care services offered, the more likely it is for primary care physicians (PCPs) to be used in staffing. However, within each model of clinic services, each employer's philosophy—which in turn depends at least in part on employee preferences—also has a strong impact on staffing. For example, one corporate medical director of a high-technology company with a high-wage workforce noted, "We found that having M.D.s was critical to patient acceptance of our [primary care clinic]."

However, a corporate medical director at another firm asserted that employers don't need a "BMW model" of primary care, saying, "I don't think everything has to be done by physicians; great things can be done by NPs [nurse practitioners]. The reason I like NPs is they have to do care planning in school and learn to treat the person as a whole; physicians tend to think about [discrete] problems."

Whether clinics use primary care physicians or other medical professionals, experts emphasized that hiring the

right people is key to clinic success. As discussed earlier, the "trusted clinician," who plays a central role in the primary care clinic model, has the ability to form personal connections and a bond of trust with patients. One medical director referred to this quality as the "hug factor," noting that as some clinics have expanded from an exclusive focus on occupational health into wellness and primary care, it has been difficult for some clinic staff to transition. "The challenge was that we had occupational nurses trained a certain way, and everything was about work injuries. The focus was on taking care of the injury and getting the person out [and back to work]. Over time, we needed a new skill set to deal with the person as a whole person. Some providers were able to make that jump, and others could not."

In recruiting PCPs for clinics, experts noted that clinics have some important advantages over typical community-based practices: a salaried arrangement, a controllable lifestyle, and the elimination of dealing with malpractice insurance and many administrative hassles. Perhaps most importantly, the clinic offers what one medical director called the opportunity to "get off the hamster wheel…[by] spending time with patients…counseling and not being productivity-incented." Several clinic vendors noted that these traits are highly appealing to PCPs, making it relatively easy to recruit top candidates. However, in rural areas with provider shortages, it may be hard to attract PCPs. As one expert noted, "If you're in the middle of Oklahoma and there are no doctors there today and you want to put a clinic there now, it's not going to make any difference—an onsite clinic can't guarantee our ability to recruit someone into our area and, if we can, the logistics could be expensive."

Some experts observed that clinic staff turnover poses a serious barrier to achieving the trusted clinician model. Particularly in markets with keen competition for providers, it may be difficult for clinics to retain key staff long enough to build the sense of permanence and stability necessary to the trusted clinician relationship.

At some workplace clinics with preventive and primary care services, specialist physicians are available part time. Unlike PCPs, NPs and other providers who typically are employed by clinic companies, specialists almost always work as contractors, and their clinic hours are an extension of their community practice. The types of specialists who practice on site vary widely depending on employer priorities and workforce demographics. For example, employers with an older workforce often make cardiologists available on site.

Start-up Challenges

Most respondents observed that one of the biggest challenges to establishing a workplace clinic is the initial capital outlay. The cost of building or remodeling the physical plant and installing equipment varies widely, ranging from several hundred thousand to many millions of dollars. Even at the low end, smaller employers may find it hard to overcome this barrier.

Proper scale and scope. Experts emphasized the importance of employers identifying and achieving the appropriate scale and scope of services in developing and launching workplace clinics. Before installing a clinic, an employer must take stock of its physical plant and decide whether its existing space can be reconfigured or whether a new build-out is necessary. The employer must also determine who will be eligible to use the clinic. Will it serve onsite employees only or employees from other sites, as well as dependents, retirees, and/or contractors? This decision has important implications for the size and ultimate cost of the installation.

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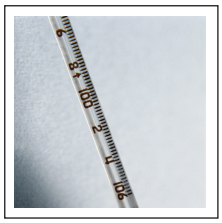

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sive array of ancillary services—such as laboratory, imaging and pharmacy—as part of the clinic. These additional offerings, which can dramatically raise a clinic's price tag, tend to be cost-effective only for very large worksites. In 2007, Toyota Manufacturing of America reported investing roughly $9 million to launch its Center for Living Well in San Antonio, which serves roughly 7,000 eligible employees, contractors and their dependents. It is a 20,000-square-foot facility that supports a laboratory, digital radiology and a full-blown pharmacy as well as primary care, dentistry, optometry and physical therapy.[6] A Toyota representative indicated that the company achieved breakeven in direct medical costs after roughly 2.5 years and also benefited from increased employee satisfaction and reduced absenteeism.

According to most respondents, however, it rarely makes sense for the typical employer to implement clinics with a comprehensive array of ancillary services. In one case, a vendor implementing a workplace clinic advised the client against installing extensive laboratory services, which the vendor judged unlikely to be cost-effective for a population of 1,300 employees. The employer went forward despite the recommendation, and some laboratory services, such as measurements of thyroid function, eventually were discontinued because of low utilization. Similarly, providing extensive onsite imaging or pharmacy services may be practical for very large worksites in smaller communities with few community-based alternatives but less so in urban areas where many alternative providers are easily accessible. Rather than operating full-blown pharmacies, clinics usually offer onsite dispensing of a limited number of commonly prescribed, pre-packaged medications and also may arrange for prescription deliveries from local pharmacies.

Capital expenditure for clinics can rise substantially, not only because of the types of services provided, but also because some employers want to create as upscale a clinic environment as possible to bolster their corporate image. One large employer noted that every aspect of its clinic—from the award-winning architecture to the latest imaging technology—was designed to be state-of-the-art to reinforce the company's high-quality image among employees.

Whether an employer opts for the deluxe or the basic, experts stressed that the physical environment of a workplace clinic needs to be accessible, pleasant and comfortable, and provide privacy if the clinic is to attract patients. A benefits consultant observed, "We've heard complaints, like the clinic is cramped [or] unappealing; some have locations that are not optimal—a basement location, for instance—or some have a waiting room with a wall of glass. While waiting for the nurse or doctor, they can be seen by coworkers walking by and they would rather not [have to] answer questions later."

Getting patients through the door. Attracting patients is one of the most important challenges for new workplace clinics. As one clinic vendor observed, "You can't assume that once you build it, they [employees] will come." Lack of awareness among employees is a key issue, particularly when launching a clinic. One benefits consultant stressed the need for outreach using a variety of methods to connect with different types of employees, including e-mail, newsletters, bulletin boards, fliers, home mailings, health fairs and information sessions. At the MillerCoors plant in Milwaukee, new employees receive a tour of the clinic during orientation, and every few weeks, a clinic provider sends personalized letters welcoming new employees and encouraging them to use the clinic. One expert suggested that having senior corpo-

rate leaders use the new clinic in a highly visible manner is an effective way to boost awareness and interest among the workforce. Outreach to dependents is even more challenging, because many of the communication channels do not apply.

Even when employees are aware of clinics, they may hesitate to use them. Skepticism of employers' motives for launching clinics is a key reason why employees may steer clear. This tends to be an issue particularly when there has been a history of adversarial relationships between management and labor. In cases where workplace clinics have expanded beyond an occupational health foundation to encompass wellness and primary care, the legacy of the "company doctor," whose objective was to get people back to work quickly and avoid workers' compensation claims, can hinder the clinic's success, according to one corporate medical director.

Mistrust also can arise from employees' concerns about potential misuse of personal health information. They may worry that data collected in the clinic will be shared with their employer and have negative consequences, including job loss. Experts emphasized that employers need to expect these concerns and work with vendors to ensure that the handling of confidential employee data fully complies with federal and other regulations and then communicate clearly with employees about these protections.

Several experts emphasized that word-of-mouth recommendations from other employees are ultimately the most powerful tool in developing trust. They also noted that it is a tool that takes time to develop and requires patience. As one clinic director observed, "You need enough people to come in and have a great experience every time [and] talk about it. The No. 1 best way for a new practice [to grow] is [through] word of mouth." Employee hesitation to use the clinic also may stem from perceptions that the quality of care delivered onsite is inferior. "The mindset is that only second- or third-rate doctors work at the clinic; if they were top-notch they would work in their own practice," a benefits consultant said.

Given that it may take time for clinics to attract patients, respondents stressed the need for employers to plan activities designed to generate interest and get patients in the door. A benefits consultant highlighted several strategies: preventive screening reminders, flu vaccinations and health risk assessments with follow-up health coaching.

Experts observed that predicting utilization can be a challenge at the outset. While it often takes time for clinics to develop a following, the opposite can happen: The presence of lower-cost, convenient care at the workplace can lead to an initial spike in demand, especially in communities with provider shortages or other access barriers. One vendor working with many clients located in primary care shortage areas noted that up to half of clinic users reported having no primary care provider or having one but not seeing them recently because of long appointment wait times or other negative experiences. People who otherwise would not have sought care may suddenly flock to the clinic. Shortly after opening, the onsite clinic for Charlotte County Public Schools in Florida was flooded with employee calls complaining they couldn't get an appointment soon enough.

Other Key Challenges

As previously mentioned, when developing onsite clinics, employers must decide who will be eligible to use them. To some employers, making clinics available to dependents of employees is critical because a significant portion of health care spend-

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Employers seeking to open clinics to dependents face many practical problems. First, there is the issue of capacity: to broaden clinic eligibility to dependents typically requires a clinic at least twice the size of an employee-only facility. Employers also face access, security or safety concerns. One consultant noted that clients in the aerospace and government defense industries could not let non-employees on site for security reasons, while clients in heavy industry and the chemical industry could not allow access for safety reasons. Some employers have addressed these concerns by locating clinics on the perimeter of their campuses to accommodate non-employees; however, many other employers continue to grapple with this issue. Experts noted that in some cases, employers are hesitant to extend clinic benefits to non-employees because, when launching a clinic, they prefer to "dip their toes in the water" by first establishing the clinic successfully on a smaller scale for employees only.

Experts agreed that retiree eligibility for onsite clinics is increasingly rare—reflecting the steep decline in employer coverage of retiree health benefits. Many of the same challenges that apply to dependents also apply to retirees, including space, security and accessibility limitations.

Achieving the appropriate scale and scope of services is important not only when launching a new clinic but also throughout its life cycle. A clinic may need to increase hours or add staff as its eligible population grows or as the facility becomes more popular with employees. Conversely, a clinic may need to downsize if the workforce shrinks or its composition changes. For example, in a worksite that transitioned from manufacturing toward more white-collar work, demand for clinic services declined as the employee population shifted to a younger and healthier demographic profile.

Experts emphasized the importance of conducting regular and ongoing evaluation of clinic utilization and performance. At Pitney Bowes, for example, a clinic executive frequently reviews the number of visits and hours of operation to estimate an internal efficiency index and determine whether staffing levels and clinic hours need to be adjusted. Many employers and vendors survey employees on a regular basis to gather information about their satisfaction and perceptions of the clinic to determine what is working well and identify areas for improvement. Employers and vendors reported very high satisfaction levels among clinic users, often in the range of 96 percent or higher. However, one employer cautioned, "There is clear selection bias when doing a survey [of clinic users]. Users are typically satisfied, otherwise, they're not using the clinic." This respondent suggested an alternative measure of the clinic's popularity: the levels and changes in the proportion of the total eligible population that uses the clinic.

As noted earlier, even when an employer outsources clinic management and operations to a third-party vendor, the employer needs to remain engaged in clinic operations and outcomes. As one benefits consultant noted, "You [the employer] cannot simply plop the clinic in place and walk away. You need to be invested." Many respondents agreed, noting that whatever entity runs the clinic, the employer ultimately owns the clinic, and strong, ongoing oversight and support by senior leadership are key to the clinic's survival and success. In recognition of this fact, one large employer noted that its benefits director holds biweekly meetings with the clinic vendor to discuss operational and budget issues, track progress, and identify and resolve problems. A vendor who pro-

vides turnkey clinic services but stressed the importance of employer engagement said, "We take [this approach] so far that we have [employers] interview the final candidates for the nurse practitioners and physicians, because the clinic becomes an extension of HR [in the] organization."

Finally, several respondents stressed that senior corporate leaders need to find the right balance between too little and too much engagement, noting that excessive involvement in day-to-day clinic operations or insistence on unreasonable timeframes for returns on investment are counterproductive.

Government Regulations Affecting Workplace Clinics

In sponsoring onsite clinics, employers have to navigate a complex array of medical, labor, real estate and data security regulations, at both federal and state levels. This is one reason that employers often outsource clinic management and operations to vendors with more expertise in handling these regulatory issues. At the federal level, regulations guaranteeing the privacy of employee health records are among the most important compliance requirements for workplace clinics. Several respondents also raised concerns that federal regulations governing health savings accounts (HSAs) might pose a barrier to optimal use of workplace clinics (see box on page 12 for more about this issue).

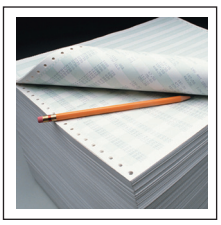
In addition to federal requirements, employers must abide by state and local regulations that govern many aspects of clinic operations, including licensure of health care facilities and providers, data privacy and access, disposal of biomedical waste, handling of laboratory specimens and storage, and dispensing of pharmaceuticals. Some states have corporate practice of medicine laws that restrict or prohibit corporations from providing services through employed physicians. State laws also vary in terms of credentialing and oversight requirements for mid-level providers, such as nurse practitioners, which can impact clinic staffing models.

Variations in state laws present a challenge for employers with locations across state lines. While different clinics can be tailored to different regulatory environments, in some cases, employers find it simpler to standardize across sites. For instance, Pitney Bowes is prohibited from extending clinic services to non-employees in Connecticut under the state's Department of Labor licensing regulations, and the company has carried employee-only eligibility over to clinic locations in other states.

Impact of Workplace Clinics

Accurately measuring the impact of a workplace clinic is complex and difficult for employers. Respondents observed that there is no single industry standard for measuring return on investment, or ROI, on workplace clinics, so it is important for employers—before launching or expanding clinics—to scrutinize alternative ROI calculation methods and reach agreement with vendors about which method to use. Two types of ROI are typically estimated: "hard ROI," which measures savings in direct medical costs only, and "soft ROI," which also includes productivity gains from such factors as reduced absenteeism.

The expected timelines for achieving breakeven on hard ROI depend in part on the scope of clinic services. For clinics exclusively focused on wellness, several experts suggested that employers should be ready to take a loss on hard ROI in the first year or two, break even in the next year or two, and begin to see reasonable returns only in the fourth and fifth year—in large part because positive impacts on employee lifestyles and health take time.[7] Employers



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Health Savings Account Rules and Workplace Clinics

HSAs are tax-exempt accounts that must be linked to health plans with high deductibles (at least $1,200 for individual coverage and $2,400 for family coverage in 2010). Under IRS rules, enrollees in HSA-eligible plans must pay full market value for medical care until they have met the entire deductible; the only exception is for certain preventive services—such as annual physicals, screenings and immunizations—for which cost sharing can be waived under a preventive care safe harbor. Some employers suggest that these regulations create a barrier to workplace clinic use, when part or all of their workforce is enrolled in HSA-eligible plans. While employers typically aim to reduce or waive out-of-pocket fees for clinic users to encourage utilization, this would be prohibited under IRS rules unless the services are preventive. Many employers have sought IRS clarification about the definition of preventive care and urged the IRS to expand its definition of preventive care.

Meanwhile, employers that have adopted the most conservative interpretation of the IRS regulations have established, in their clinics, separate cost-sharing arrangements for employees enrolled in HSA-eligible plans vs. other plans. For example, Highmark, a Pennsylvania health insurer with onsite clinics for its employees, provides clinic services free of charge to preferred provider organization (PPO) enrollees but uses a fee schedule to charge HSA-plan enrollees who have not met their deductible and who receive services that are not clearly preventive. Highmark representatives said this two-tier approach can be confusing to employees and may discourage HSA-plan enrollees from using the clinic.

Other employers have taken a more aggressive tack with respect to HSA regulations. One employer, after consulting with legal counsel, determined that all services at the clinic could be considered preventive, and therefore exempt from the deductible, provided that each visit includes a brief discussion about the employee's health risk assessment. Many experts considered this to be a risky, overly broad interpretation of the safe harbor—one that may ultimately jeopardize the tax-exempt status of employees' HSAs. It should be noted that not all experts viewed current IRS guidelines as a serious obstacle. As one benefits consultant noted, "It's still more convenient to [obtain care] at work at the same cost" as out in the community.

with high staff turnover generally will not achieve positive ROI.

For clinics providing primary care, most experts said reaching breakeven on hard ROI can be achieved earlier, because of the opportunity to impact provider practice patterns, such as drug prescribing and specialty referrals, and the ability to use early diagnosis and treatment to prevent more expensive downstream costs. Some experts suggested that breakeven on hard ROI could be achieved in the first year, but most believed a range from two years to five years to be more realistic. Most respondents were reluctant to generalize about the magnitude of hard ROI that could be achieved, noting the wide variation in clinic models, workforce demographics and other characteristics. According to one prominent benefits consultant, "Some vendors have floated… lofty ROI figures—3:1, 5:1, upwards of 7:1. That's really getting to be unrealistic…Many have had to temper their numbers." This consultant suggested that, in an equilibrium state, hard ROIs between 1 and 2 were more realistic.

Some experts measure the impact of ROI by comparing overall health costs for clinic users vs. non-users. However, they noted that this approach is confounded by two problems: sample-size constraints and selection bias—the latter because clinic use does not tend to be random. Instead, some clinic programs, such as wellness activities, often attract healthier and more health-conscious employees, while others, such as disease management, tend to attract sicker employees. Trying to disentangle these separate, opposing effects makes it difficult to correct for selection bias when comparing costs between clinic users and non-users.

Isolating the impact of workplace clinics is further complicated by the fact that these programs are seldom implemented by employers in a static environment. In particular, employers seeking to contain costs often introduce concurrent benefit design changes. As a result, some ROI calculations might mistakenly attribute cost reductions to clinic use when these savings might have been caused by benefit design changes or other factors.

Estimating indirect benefits of workplace clinics from productivity gains can be equally challenging. As one expert noted, "Over time, productivity rises in the workplace due to all sorts of changes… maybe it's better software, or better training…You can't ascribe all that to [the clinic]." Also, while time savings from using an onsite clinic instead of a community-based provider can be substantial—respondents commonly cited estimates of only 30-60 minutes away from the job compared with at least 2.5 hours—this may be less of a factor in certain professions, such as white-collar jobs where work hours and assignments are flexible.

Because of these limitations, alternative measures of impact are commonly used. One method estimates the difference between the employer's projected health care cost trend without the clinic and the actual cost trend with the clinic in place.

Employers taking this approach often benchmark their trends against those of similar companies in their community or industry, or against other worksites (without clinics) within their own company. However, making accurate comparisons may be complicated by differences in workforce or benefit design changes, among other factors.

Another increasingly common approach to measuring impact is to examine the changes in an employee population's health risk factors over time. Dow, for example, tracks multiple risk factors ranging from biometric data, such as blood-pressure and cholesterol levels, to self-reported measures, including stress and diet. Employers can also track risk factors separately for clinic users vs. non-users, using methods to adjust for selection bias.

Several employers with workplace clinics emphasized the importance of considering the broader impact, including the effects that clinics have on employee loyalty and morale and on enhancing the firm's reputation and brand.

Recent Trends

High public employer interest. In recent years, interest in workplace clinics has been especially high among public employers, including municipal governments and school systems. Because public employers tend to have low staff turnover and to maintain rich health benefits compared to the private sector, they have strong motivation to use workplace clinics to contain costs and to keep employees healthy. Like their counterparts in the private sector, public employers have implemented a variety of clinic models, with some focusing exclusively on wellness and others offering more comprehensive primary care.

Whatever the scope of their clinic services, one challenge that many public employers share is that their employees are seldom concentrated at a single worksite—meaning that an "onsite" clinic can actually be several miles offsite for many employees. Despite the lack of onsite convenience, experts noted that employees may still be drawn to the clinic for other reasons. For instance, the Charlotte County Public Schools found that employees flocked to the workplace clinic to save on out-of-pocket costs because all services are free. Other experts noted that clinic users often are willing to travel some distance to the clinic when it serves as a "one-stop shop" for a variety of medical needs or provides services that are not readily accessible elsewhere in the community.

Employers join forces to operate clinics. Interest among employers in joining together to cosponsor clinics is an emerging trend. Many respondents referred to minimum size thresholds needed for onsite clinics to be economically feasible. These estimates ranged from the high hundreds to several thousands of workers. Among employers that fall below these thresholds, there has been interest in collaborating with other employers under a near-site model. This type of collaboration can take a variety of forms: one employer can sponsor its own clinic and make the services available to employees of other nearby companies; alternatively, several employers in the same office or manufacturing park can cosponsor a shared clinic in a mutually convenient, neutral location. There are even cases of industry competitors collaborating on clinics—rival mining companies currently cosponsor clinics in Colorado, Nevada and Wyoming.

Shared clinics are appealing to many employers—particularly mid-sized employers—because they require a smaller financial commitment, but experts noted that employers considering these arrangements face several key challenges. First, it can be difficult to identify potential partners

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For employers without the critical mass to sponsor a full-time clinic, another emerging option is the use of mobile medical vans that travel to different worksites—an approach being piloted by both established clinic vendors and start-up companies.

that share similar business requirements, philosophies of care delivery and levels of corporate commitment. Also, an expert noted that it can be challenging to get different employers, each "with [their own] brands and egos, to play nicely in the same sandbox." As a result, despite what seems to be keen interest from many employers, collaborative clinics remain relatively uncommon.

For employers without the critical mass to sponsor a full-time clinic, another emerging option is the use of mobile medical vans that travel to different worksites—an approach being piloted by both established clinic vendors and start-up companies. The use of mobile vans in the workplace is still in a very early stage of development, but some experts find the concept promising.

Key Takeaways

Among the common themes that emerged from interviews with industry experts and employers sponsoring workplace clinics, the following stand out:

The trusted clinician model of wellness/primary care delivery hinges on having the right staff. One of the most promising aspects of workplace clinics is their potential to transform the delivery of wellness, disease management and primary care by developing a relationship between the patient and the trusted clinician, who may be a primary care physician or other health provider. Through longer, more frequent face-to-face encounters that emphasize holistic rather than acute, episodic care, this model distinguishes itself from most community-based care. Achieving this model is contingent on finding and retaining clinic staff with the right skills and qualities.

Whoever runs the clinic, sustained employer engagement is critical to success. Most employers outsource clinics to vendors, but experts noted that no successful clinic is completely a turnkey operation. Senior leaders not only need to provide active, visible support at start-up but also need to remain engaged throughout the life of a clinic. Achieving the appropriate balance between too much and too little corporate involvement is a challenge. Without micromanaging, employers need to keep vendors accountable while also providing the support and resources necessary for the clinic to thrive.

Gaining employee trust is key to clinic acceptance. When clinics are first introduced, employees may be mistrustful of employer motivations, concerned about personal data confidentiality and skeptical about quality of care. Employers need to expect these concerns, communicate clearly and honestly about how the clinic fits into the company's core business strategies and demonstrate convincing evidence of patient privacy protections. Employers also need to be patient in allowing employee trust to be built through first-hand personal experience and recommendations from early clinic users.

Investing in the appropriate scope and scale of clinic services is challenging but essential. At start-up, some employers take such a cautious and incremental approach that the clinic makes little impact on care delivery or cost containment. Other employers take a no-expenses-spared approach, building state-of-the-art facilities with comprehensive ancillary services—an approach that might pay off in reputation and brand but makes it difficult to recoup direct medical costs. Throughout the life of a clinic, services and staffing need to be monitored and adjusted to meet changing business needs or shifting workforce demographics.

Employers should be realistic about return on investment and that measurement poses challenges. While some argue

that clinics can achieve a positive ROI in the first year, many experts suggested that employers should not expect to break even for at least two years or possibly longer, especially if conservative measures of hard ROI (direct medical costs) are used. Employers should not look to clinics as a quick fix for high health costs, because savings from population health improvement take time, even in the most effective programs. In addition, some experts estimated hard ROIs for many clinics range between 1 and 2, suggesting that while well-designed, well-implemented clinics may prove wise, financially viable investments for employers, the magnitude of savings is unlikely to make clinics "game changers" in bending the cost curve substantially overall. There are many challenges in accurately capturing ROI or alternative measures of impact, and because workplace clinics are often implemented in conjunction with other benefit changes, isolating the impact of clinics on employer cost trends may not be possible.

Policy Implications

A central policy question concerning workplace clinics is whether the model of employer-sponsored wellness and primary care delivery is likely to function more effectively with or without active encouragement from government. The new federal health care reform law contains provisions facilitating workplace-based wellness programs[8]—reflecting the view of many policy makers that such programs merit some degree of federal support—but there are some in the workplace clinic industry and the employer community who suggested that the new legislation has not done enough to promote such programs. These proponents contended that the federal government should support employer-sponsored wellness programs through tax credits. However, the evidence to date suggests that the gains from such programs are uncertain, and, in situations where gains are most likely—low turnover and highly engaged employers—the likely positive returns provide sufficient employer motivation to pursue programs. The major impact of subsidies might be stimulating programs less likely to succeed.

Workplace clinics that provide primary care have the potential to improve access to care for eligible employees and dependents, but some observers have expressed concern about the potential aggregate impact that clinics may have on community-based primary care in the surrounding areas. If onsite clinics continue to grow and a greater portion of primary care for well-insured patients continues to shift to the workplace, their concern is that primary care practices in the community will be left with an increasingly less viable payer mix.[9] This is an issue for policy makers to be aware of as they consider whether to actively encourage the growth of workplace clinics.

Growth in onsite primary care clinics also has the potential to exacerbate shortages of community-based primary care physicians and other providers in some areas. This concern is likely to become more acute over the next few years, with demand for primary care expected to increase substantially as perhaps 30 million or more people gain coverage nationwide under health reform.

Notes

1. Watson Wyatt Worldwide, *Companies Not Fully Tapping Potential of Onsite Health Centers*, Press Release, Washington, D.C. (March 19, 2008); Mercer, *Survey on Worksite Medical Clinics* (2008); Towers Watson, *2010 Health Care Cost Survey, Workforce Health 2010: New Deal, New Dividend* (February 2010).
2. It is not surprising that the population estimate of clinic use is substantially

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lower than the large-employer estimates of clinic implementation. Among other reasons, many Americans are employed by small or mid-sized companies that typically are not candidates for workplace clinics, and among people with access to workplace clinics, many choose not to use them.

3. Gunsauley, Craig, "Home-Grown Network: Building a Better Health Benefit, Perdue Farms Contracts Directly with Physicians and Hospitals," *Employee Benefit News*, Vol. 15, No. 9 (July 2001); Wells, Susan J., "The Doctor is In-House," *HR Magazine,* Vol. 51, No. 4 (April 2006).
4. McCarthy, Douglas, and Sarah Klein, *QuadMed: Transforming Employer-Sponsored Health Care Through Workplace Primary Care and Wellness Programs*, The Commonwealth Fund (July 2010).
5. Schilling, Brian, *Is an Onsite Clinic Right for Your Firm?* The Commonwealth Fund (May 2010).
6. Glabman, Maureen, "Employers Move Into Primary Care," *Managed Care*, Vol. 18, No. 6 (June 2009).
7. Tu, Ha T., and Ralph C. Mayrell, *Employer Wellness Initiatives Grow, But Effectiveness Varies Widely,* Research Brief No. 1, National Institute for Health Care Reform, Washington, D.C. (July 2010).
8. PPACA includes $200 million in grants to allow small businesses (with fewer than 100 employees) to implement wellness programs. In addition, under PPACA, maximum wellness incentives will be increased to 30 percent (from the current level of 20 percent) of the total premium by 2014, with the possibility of raising the maximum incentive up to 50 percent of the premium if deemed appropriate by the secretaries of the U.S. Treasury, Labor and Health and Human Services departments.
9. Terry, Ken, "Worksite Clinics—The Next Threat?" *Physicians Practice*, Vol. 19, No. 7 (May 2009).

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