

# Worksite Clinics and the Patient-Centered Medical Home: Competition or Collaboration?

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Unremitting healthcare cost increases have prompted employers to seek progressively more innovative approaches to managing medical expenditures. These have generally included patient-focused or demand-side interventions, including value-based insurance design and widespread use of incentives, in an effort to direct individuals toward high-value services. Progressive employers now are expanding their attention to health system-focused (supply-side) interventions intended to improve the quality and efficiency of care delivery. Two supply-side interventions attracting increased employer interest are worksite clinics and the patient-centered medical home (PCMH).

Although each of these strategies may generate value for employers, a combination of both may provide even greater synergy. In this Commentary, I highlight the specific merits of and concerns about these approaches, and conclude by discussing the broader value of effectively integrating worksite clinics with PCMHs.

## WORKSITE CLINICS

Employer use of worksite clinics to address employee health concerns is not new, as this type of clinic was associated with the mining and lumber industries early in the 20th century. Since that time, employers in an array of industries have incorporated worksite clinics for a range of business reasons such as reduced healthcare costs, maintenance of work productivity, and increased employee satisfaction, among others. In the past few years, there has been a resurgence of interest among employers in nonoccupational care provided by worksite clinics, based largely on expectations of healthcare cost containment. Employers can customize worksite clinic services to more effectively address identified population health needs, based on detailed claims analysis and review of health risk assessment data. Additionally, direct, cost plus contracting between employer and vendor or clinician, as well as process- and outcomes-based performance guarantees, help to more effectively align mutual interests to ensure cost-effective and efficient care delivery.

However, worksite clinics have their issues. Perhaps of greatest importance, there is no standardized methodol-

ogy for quantifying return on investment for these services; the methodologic flaws include those noted in the disease management industry.<sup>1</sup> With primary care physician costs representing only about 7% of total employer healthcare expenditures,<sup>2</sup> it can be difficult to appreciate how these services can have such a dramatic projected overall impact on employer healthcare cost trends. This concern is particularly relevant in settings where there is poor communication between worksite clinics and community providers, resulting in the potential for further fragmentation of care.

Worksite clinic services have the potential to favorably impact employer healthcare costs when they are appropriately implemented. A worksite clinic can serve as an easily accessible facility for employees to learn about and receive counseling for lifestyle behaviors and chronic conditions, and get point-of-service monitoring of chronic health conditions. (It should be noted, however, that little evidence is available to support the belief that early diagnosis and treatment of acute medical conditions, minimizing symptom duration, will save money and improve productivity.) In addition, worksite clinics can facilitate referrals to community healthcare resources, as well as other employer-provided health benefits, thereby maximizing the value of available health-related programs.

## PATIENT-CENTERED MEDICAL HOME

Interest in the PCMH as a central component of healthcare reform has markedly increased during the past few years, as recognition of the potential for improvements in healthcare quality and clinical outcomes has become more widespread. Pilot program data have demonstrated the consistent cost savings through reductions in ambulatory care-sensitive hospitalizations and emergency department use that result from improved care coordination and management.<sup>3</sup> Additionally, patients seen in PCMH settings may be more compliant with recommended medical care, particularly if they have a “connected” relationship with their physician.<sup>4</sup> Finally, limited data suggest that both

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patients and providers may be more satisfied with the health-care delivery experience in the setting of a PCMH.<sup>5</sup> Taken together, favorable clinical and quality outcomes, healthcare cost reduction, improved patient compliance, and stakeholder satisfaction make PCMH an attractive option.

Despite the growing enthusiasm for the PCMH, more experience is needed to help identify best practices with respect to staffing and payment models for care delivery, which will then likely provide the basis for accelerated adoption of this care delivery strategy. Practice transformation for primary care requires effort and investment, and with already high healthcare expenditures, employers may be unwilling to spend additional funds on healthcare without clear evidence of a predictable and timely return on investment. Patient-centered medical home pilots are ongoing in a number of communities with early promising results, but scalability issues for a more widespread adoption of this model, particularly in light of primary care shortages, need to be more comprehensively addressed.

With accumulating data regarding clinical outcomes and healthcare cost savings, the use of PCMHs as an effective strategy for improving healthcare is continuing to gain supporters. Although this approach has been largely driven by provider groups, health plans, and state programs, employers are taking notice and becoming increasingly involved in PCMH program implementation.<sup>6</sup>

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## OPPORTUNITIES FOR SYNERGY

Although these 2 strategies for healthcare cost containment, quality improvement, and clinical outcome improvement can each be considered on their individual merits, effective integration of both strategies may offer even greater value.

Worksite clinics can provide support for community-based PCMHs by serving as a bridge between patients and their primary care physicians. In this capacity, clinic personnel can provide ready access to support for chronic condition management, with point-of-care testing and communication of results to PCMH providers for further action. Additionally, worksite clinic personnel can provide health education and lifestyle counseling to minimize the burden for community clinicians unaccustomed to providing these comprehensive services. In this capacity, worksite clinics can serve as a physical extension of the community-based PCMH.

Alternatively, PCMH practitioners may be able to enhance their effectiveness by leveraging worksite clinics to provide readily available services that could pose access and convenience challenges for patient engagement if they were PCMH office based. Such may be the case for lifestyle coach-

ing, monitoring of chronic condition management, or classes. If worksite clinics could provide these services, PCMH office staff would be free for more essential patient care functions, which could have the secondary benefit of increasing PCMH capacity for additional primary care patients. However, any shift of services away from the PCMH may have an adverse impact by diluting the patient–primary care physician partnership. Further evaluation of the role of worksite clinics in the setting of PCMH is needed to clarify this issue.

Although worksite clinics are a well-established health-care option, only a small minority of employers have chosen to provide comprehensive, worksite-based PCMH services. Many worksite clinics do not effectively integrate their offerings or clinical data from patient encounters with those of community healthcare providers. Furthermore, the scope of worksite services may be limited to minor nonoccupational health concerns and may not formally address lifestyle coaching or chronic condition management. A significant opportunity exists to expand the role of worksite clinics to more effectively integrate their services with those of community primary care providers, even in the absence of community-based PCMH availability.

Employers with existing worksite clinics should consider how incorporating PCMH into their care delivery model can help to improve the quality and effectiveness of patient care by providing enhanced care coordination and greater focus on treatment outcomes. Employers who are engaged in PCMH programs may wish to expand the effectiveness of those community-based programs by leveraging worksite clinics to provide health education, point-of-care testing, and facilitated communication between patients and PCMH clinicians.

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## LOOKING AHEAD

To more effectively integrate worksite healthcare services with community-based primary care, future considerations should include more widespread implementation of health information technology to facilitate secure, 2-way information exchange between these 2 sources of care. This technology infrastructure then can provide the basis for more effective service integration.

One way to accelerate alignment of treatment goals for worksite clinics and PCMH clinicians is to effectively align payment incentives, with a reimbursement model that incorporates a shared basis for an outcomes-based payment bonus. With this approach, both the PCMH and the worksite clinic can receive a performance-based payment if their shared patient achieves desired treatment goals, and neither will receive remuneration if treatment goals are not reached. By aligning the financial interests of the providers in the 2 care

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settings, collaborative treatment between worksite clinics and PCMHs is considerably more likely to be successful.

In summary, worksite clinics provide employees with enhanced access to healthcare services, and PCMHs afford employees a means to receive higher quality, more efficient, and coordinated care within the community healthcare system. Employers have a choice as to whether they consider worksite clinics as a replacement for or a valuable adjunct to community-based primary care. If these clinics are viewed as a substitute for community-based services, it is unlikely that healthcare costs will be meaningfully impacted because of the relatively small contribution of primary care services to employer healthcare expenditures. Used together, these services have the potential to complement each other, further enhancing improvements in quality care delivery and health outcomes.

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