
A COMMUNITY PARTNERSHIP:

The Whirlpool PCMH Journey



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Global Benefits

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WHIRLPOOL CORPORATION

World's leading marketer and manufacturer of home appliances

\$17 billion in revenue in 2009

67,000 employees

67 manufacturing and technology centers

LEADING BRANDS:



WHY PCMH?

COMMUNITY-EMPLOYER CONNECTION

- Capitalize on physician-patient relationship
- Shift responsibility for lifestyle and chronic condition management to PCP
- Works in tandem with plan design and onsite services
- Evidence-based guidelines for care
- Pay for performance
- Control cost of care

“30% of all healthcare costs are due to poor quality issues in delivery and administration.”

Source: Institute of Medicine, Juran Institute, 2007

Medical Home:

Evidence based guidelines for care coupled with employee outreach

- 54.5% of commercial insurance patients had appropriate colorectal cancer screen; other physicians “forgot” to recommend
- 40% of patients being treated for hypertension were not in normal range; treat to lower level but don’t strive to bring to normal range
- Only 51% of diabetes patients received eye exams
- 78% of diabetic patients had HbA1c test but 48% still had A1c out of range
- If you reduce A1c from a 9 to a 7, decrease risk of blindness, amputation and renal failure by 65%
- 80% of patients had lipid panel done but only 33% achieved normal levels

With the medical home, we are able to steer the medical quality of care and influence patient compliance at the most critical action point.

Source: Commonwealth Fund, 2009

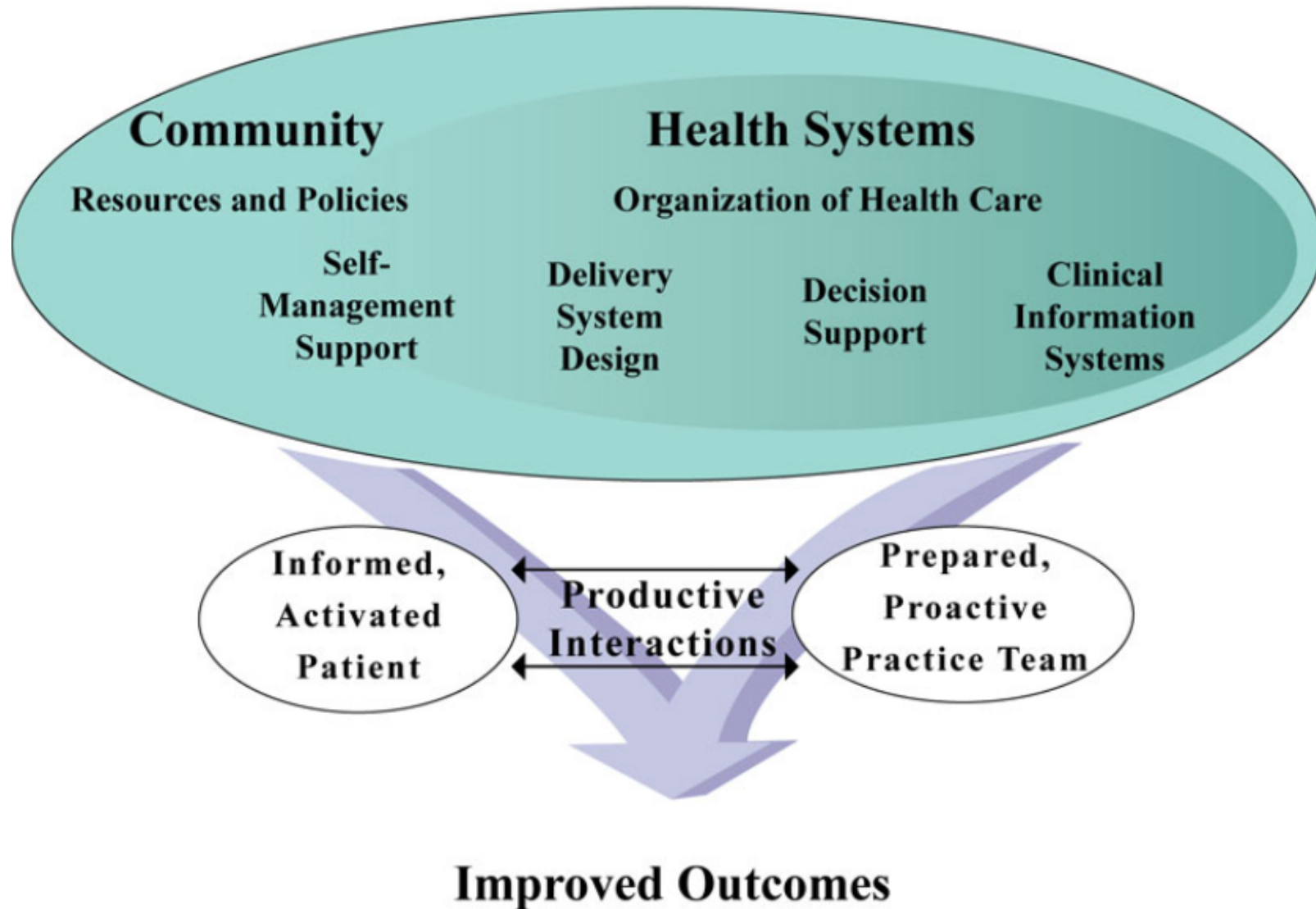
What is a Medical Home?

“A continuous relationship with a personal physician coordinating care for both wellness and illness”

Based on Wagner Chronic Care Model concepts: self-management, decision support, delivery system design, clinical information systems, organization of health care, and community

Source: American Academy of Family Physicians

The Chronic Care Model



Developed by The MacColl Institute
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FINDLAY AREA COMMUNITY MEDICAL HOME

KEY COMPONENTS

- Auto-enrollment for members
- Outreach
- Registry
- Care plans
- Care coordination
- Provider access
- Performance and metrics

KEY IMPLEMENTATION MARKERS

- Conceptual discussions with hospital system began 8/1/09
- Focus groups 3/1/09
- Aligned plan design to compliment medical home 6/1/09
- TPA assigned primary care physician using claims data 9/15/09
- Medical Home rollout 1/1/10

SUCSESSES: EARLY INDICATORS

Approximately 1800 participants enrolled
42 Participating physicians

Improvement in number of primary care visits

Improvement in number of preventive services provided

Evidence based guidelines are being followed

Excitement of providers and members