

Beyond Notifications: Driving Outcomes in Skilled Nursing Collaboration with Real-Time Clinical Insights

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PointClickCare®



PointClickCare

North America's Most Comprehensive Care Collaboration Network

2,800+
Hospitals

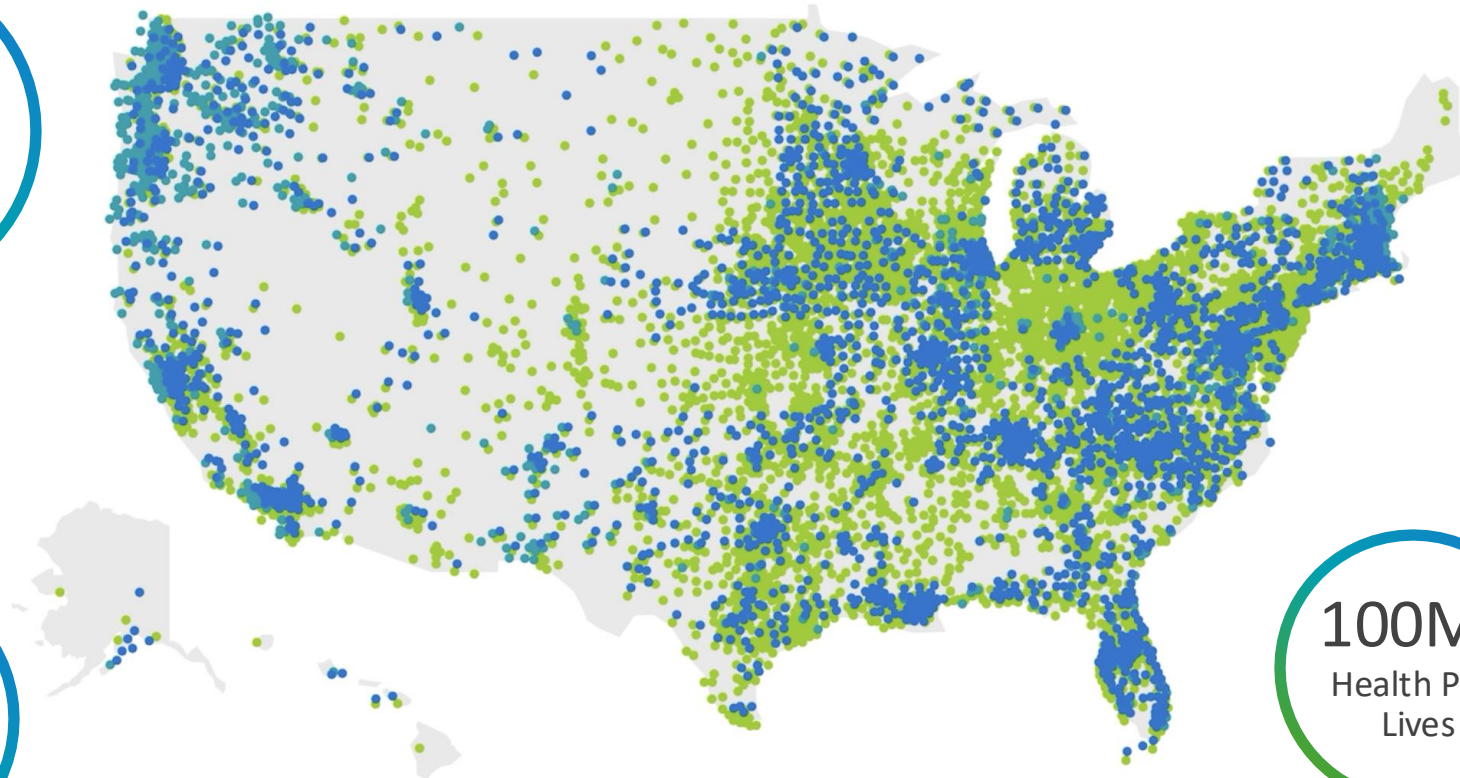
350+
ACO & Risk-
Bearing Provider
Organizations

3,600+
Ambulatory
Clinics

27,000+
Long-Term and
Post-Acute Care
Providers

70+
State and
Government
Agencies

100M+
Health Plan
Lives



● LTPAC Providers

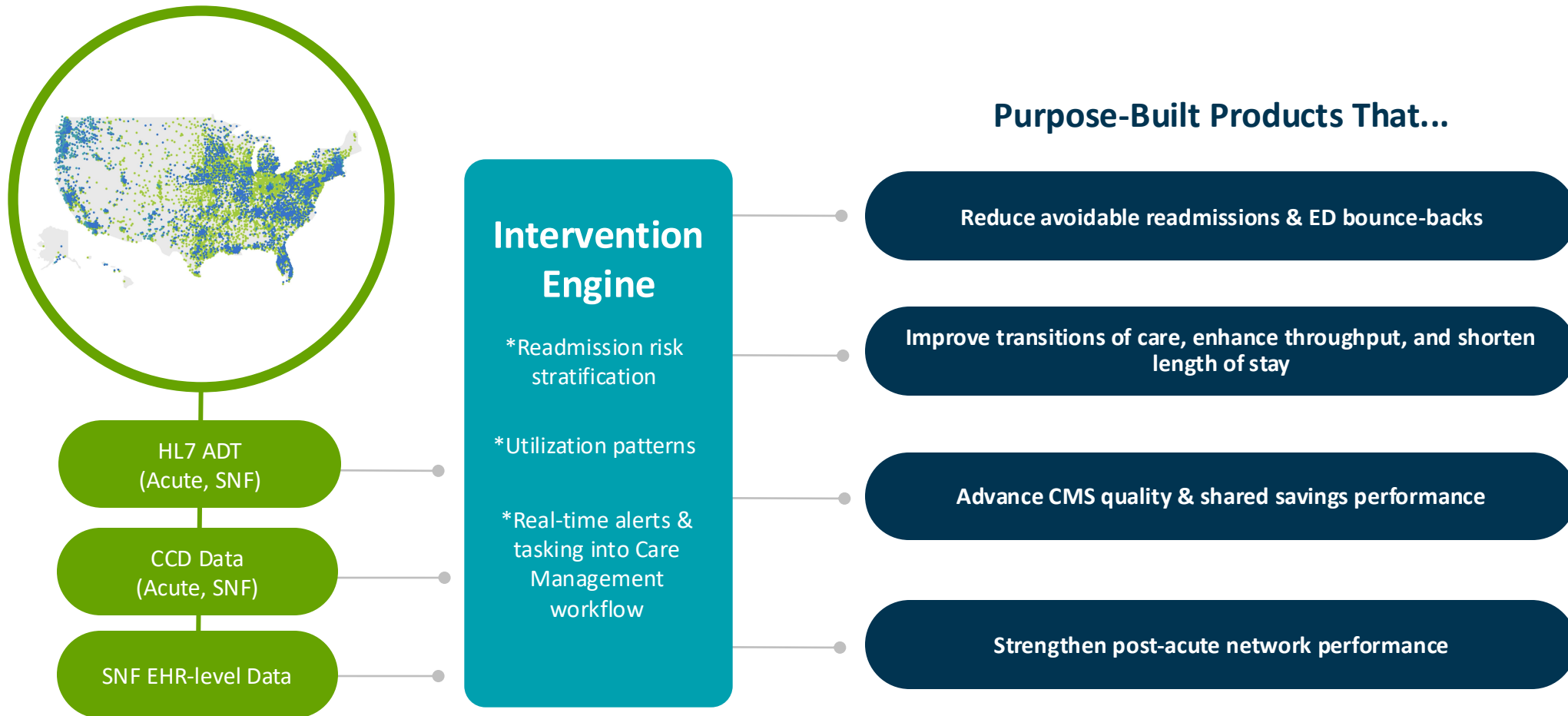
● Additional Providers

● Hospitals

300+
integrated solutions as part
of the Partner Marketplace

100+
national and regional association partnerships with
organizations such as CMS, AHIP, HIMSS,
AHCA, Argentum, Leading Age

PointClickCare Turns Clinical Signals into Coordinated Actions



Providers: go from fragmented data to proactive intelligence – so care teams can intervene earlier and discharge safer.

Tandigm at-a-Glance: A Population Health Management Company

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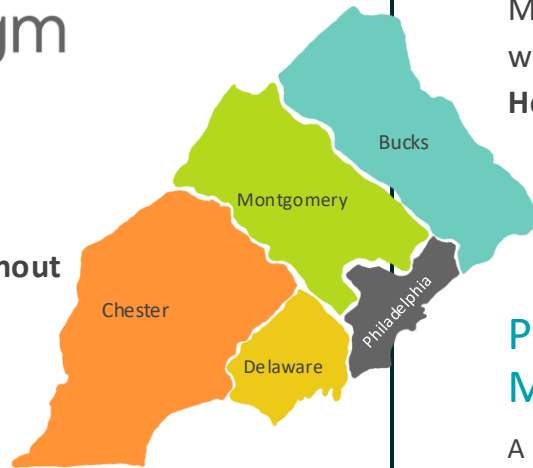
Independence 



Established 2014

Network

More than **1,100 primary care providers** serving
≈ **200K patients** across **nearly 400 locations** throughout
5 Philadelphia counties
and expanding.



Payors

Multi-Payor and Multi-Product

Independence 

- > Medicare Advantage HMO & PPO
- > Commercial HMO



- > Tandigm Value Partners
- > Doylestown Value Partners
- > Penn Medicine Healthcare Partners

Humana

- > Medicare Advantage HMO
- > PPO, PFFS



- > Medicare Advantage D-SNP

aetna

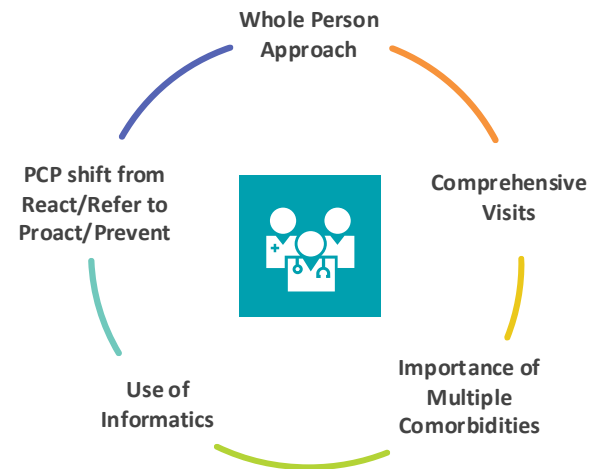
- > Medicare Advantage HMO & PPO

People

Mission-driven community of **245 employees**, with **20%** of workforce who are **clinicians**, along with team of **experts across the Population Health and Value-based Care continuum**

Population Health Management

A model of **care** focused on:



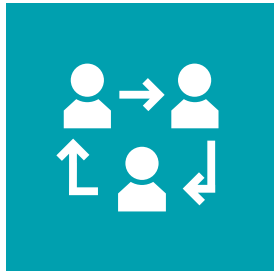
Value-Based Care

A model of **funding** that rewards:

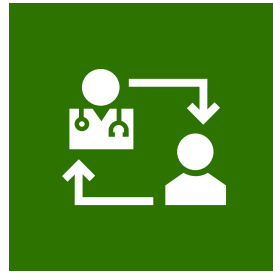


Tandigm's Clinical Post Acute Product

Four Primary Levels of SNF Interventions



Joint Operating
Committee Structure



Provider
Collaboration



RN Care Manager
Interventions



Multi-Disciplinary
Case Review

Barriers to Success

Only 50% of SNF ADT Captured by Regional HIE

Missing admissions and discharges hinder care coordination

Limited SNF EMR Access

Only a portion of 100+ SNFs provided access to their EMR, and some only if on-site

Need for Strategic Insights on LOS & Readmissions

- Claims lag
- Limited ability to evaluate provider outcomes

PointClickCare (PCC) PAC Management Value

7



Identification

Increased SNF population identification to 95% (HIE + PCC)



Clinical Data Access

Real-time access to vitals, labs, meds, code status



Business Intelligence

Improves committee function and SNF collaboration



Provider-Level Data

Enables collaboration with SNFist groups



BONUS!

AI-Driven Insights

SNF RNs prioritize high-risk patients, reducing avoidable hospitalizations



Outcomes

> Implemented PCC 7/1/24

Medicare Advantage	Pre-PCC	Post-PCC	% Change
SNF Days/K	1,173	1,025	(13%) ↓
SNF ALOS	18.5	18	(3%) ↓
SNF Readmissions	17.7%	16.6%	(6%) ↓

MSSP	Pre-PCC	Post-PCC	% Change
SNF Days/K	1,344	1,345	0%
SNF ALOS	22.2	23.6	6%
SNF Readmissions	17.6%	15.7%	(11%) ↓

Comparison of pre-PCC (Jul 2023- June 2024) and post-PCC (Jul 2024 – April 2025)

Discussion: Lessons Learned in Post-Acute Care Management

- How were you able to take this from idea to full buy-in from leadership (“the business side”)? What specific business metrics did you anchor to?
- How do you see the evolution of value-based contracts at Tandigm? Do you see membership expanding?
- What are next steps to continue and expand upon success? How will you build upon partnerships with post-acute?
- What does it look like if PCC goes away?

Q&A

Thank You!