Addressing Social Determinants of Health

Participant Storyboard Template

September 2021

NAACOS
National Association of ACOs

IAC
Institute for Accountable Care


tandigm health
SM

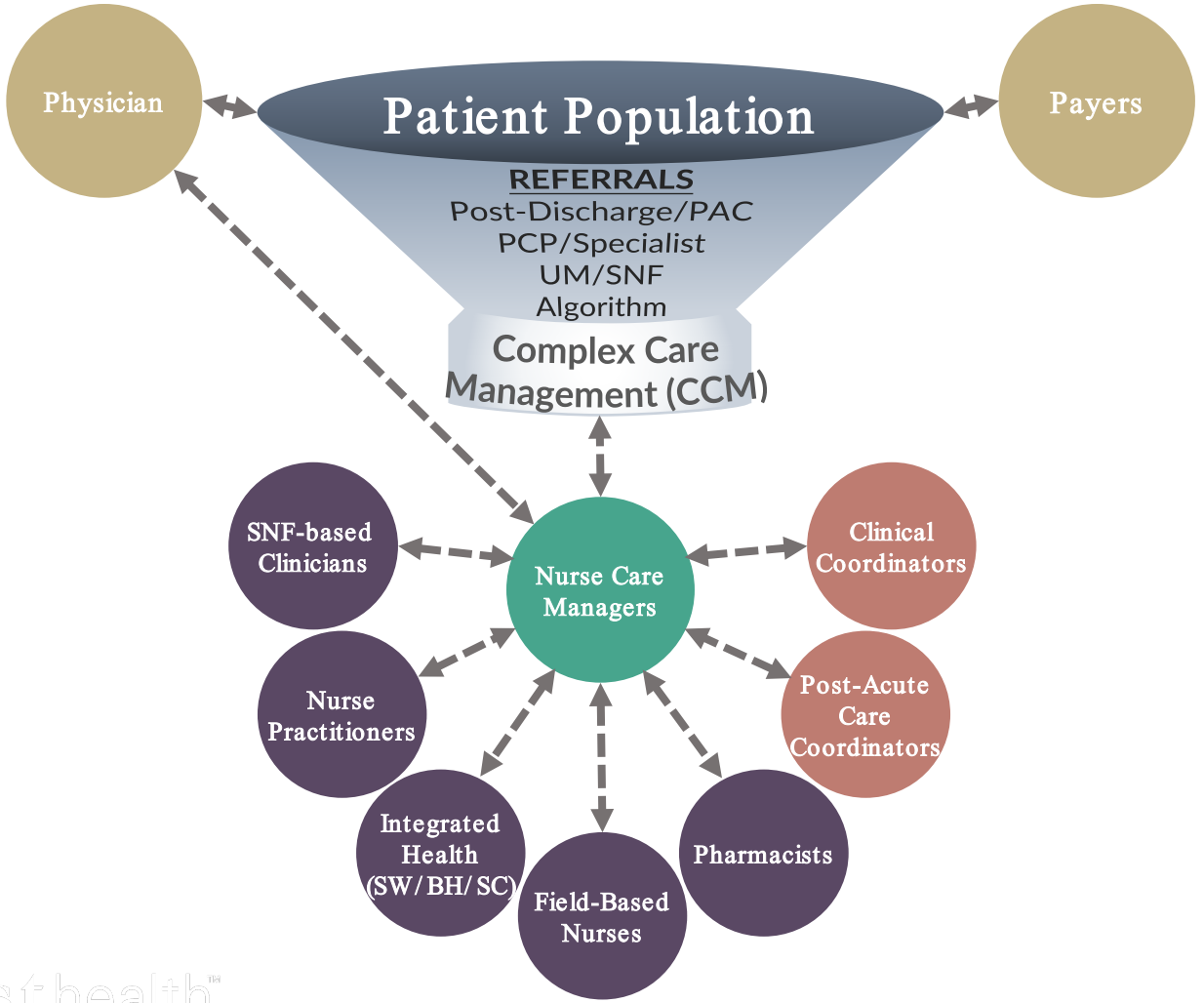
Tandigm Health

- "Population Health Services" company outside Philadelphia
- Founded 2014 to "Engage, Enable, Empower" independent PCPs
  - Contract w/ 400+ PCPs in 240 practice locations across Philly 5
  - Represent "mom & pop" shops as well as large, multi-location groups
- Risk contract w/ local Blues for total cost of care of ~100K HMO (CM & MA) & PPO (MA) lives; support PCPs with
  - Data and analytics on needs, opportunities, costs
  - Best practices in practice transformation, VBC, patient experience
  - Clinical support for highest-risk patients (~5%) via **CCM Program**
  - Incentive & quality programs to reward Quadruple Aim successes
- Newly formed ACO (Tandigm Value Partner) for MSSP (1.1.22)
  - ~12K additional member lives of Tandigm PCPs (in 2 counties)
  - First foray into MSSP/FFS Medicare patients

Complex Care Management (CCM) Program & Teammates

Julianne Marino, Director of IH

Connie Stallone, Manager of SW



Interdisciplinary team promotes a patient-centered approach using an evidence-based care coordination model targeting the highest risk patients.

Blended model of telephonic, video, and in-home/facility support, working hand-in-glove with PCPs.

This coordinated care approach allows for seamless communication and a holistic path to improve patient care plan adherence, care outcomes, and quality of life.

Your ACOs Current Efforts to Address SDOH

- Goal: identify & address bio/psycho/social/spiritual needs (in collaboration w/PCPs) to improve outcomes and experience, reduce costs
- ~12K patients in our new ACO; will focus on those at highest-risk
- Currently, info on needs of pts comes from PCPs; IBX; patients enrolled in CCM program; CCM teammates supporting them; facilities
  - For ACO MSSP members, info on needs will come from CMS rather than IBX
- Important partners include:
  - PCPS & practices; CBOs: area agencies on aging, MANNA and MOW, VA, county agencies; resource gaps: transportation, in-home supports, financial (medical bills overall; specialty copays, incl therapy; meds; dearth of psychiatry)
  - Technology/data partners: HSX, HMS Essette, Care Continuity, Aunt Bertha, Arcadia
  - Key stakeholders: ACO, PCPs, IBX, facilities (hospitals and SNFs)
- SDOH initiatives financed by Tandigm Health (for-profit organization)

Storyboard Summary: Tandigm Health

- A unique population health services organization that has helped reinstate primacy of PCP in patient lives, experiences, outcomes
- Successful local leader in VBC for more than 6 years, bringing great value to patients, enhanced earnings/incentives to 400+ contracted PCPs
- Complex Care Management program provides direct care and/or care management support to highest-risk patients with large, multidisciplinary team of RNs, NPs, physicians, pharmacists, SWs, BHCs, and clinical coordinators
- Now entering into MSSP (1/1/22) with newly formed ACO, Tandigm Value Partner
- Eager and excited to learn about this new population and to achieve Quadruple Aim for all ACO stakeholders

Tandigm's Objectives for the Collaborative

- To meet leaders working in this space!
- To learn about needs of a new-to-us population (Medicare)
- To learn how others are identifying, engaging, collaborating with CBOs
- To determine best practices for utilizing SDOH metrics and analytics
- Regarding closed-loop referrals…
  - We partnered with Findhelp (formerly known as Aunt Bertha) earlier this year
  - Launched "Tandigm Care Links Home" (TCLH) in July; SWs primary users
    - No closed-loop referrals to date; the CBOs we rely on do not accept e-referrals
    - Portal data is informing our Community Engagement Plan (under development), the goal of which is to encourage those CBOs to consider accepting e-referrals
  - Plan to launch TCLH to PCP Network by EOY


Health is
on the way.