TRIAGETRACE

Collaboration & Documentation tool to manage CoCs in SNFs

a vision of Geriatricians in LTC

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TRIAGETRACE

Smart Phone based **Collaboration & Documentation** platform to digitally manage Change of Conditions in post acute Skilled Nursing Facilities and to assist Nurses & Physicians to communicate effectively, make informed decisions, leading to better care for the residents.

Value Proposition - better patient care, improved productivity, analytics, improved survey outcomes/star ratings, reduction in unnecessary 30-day hospital transfers, managing recertification's, all leading to cost savings!

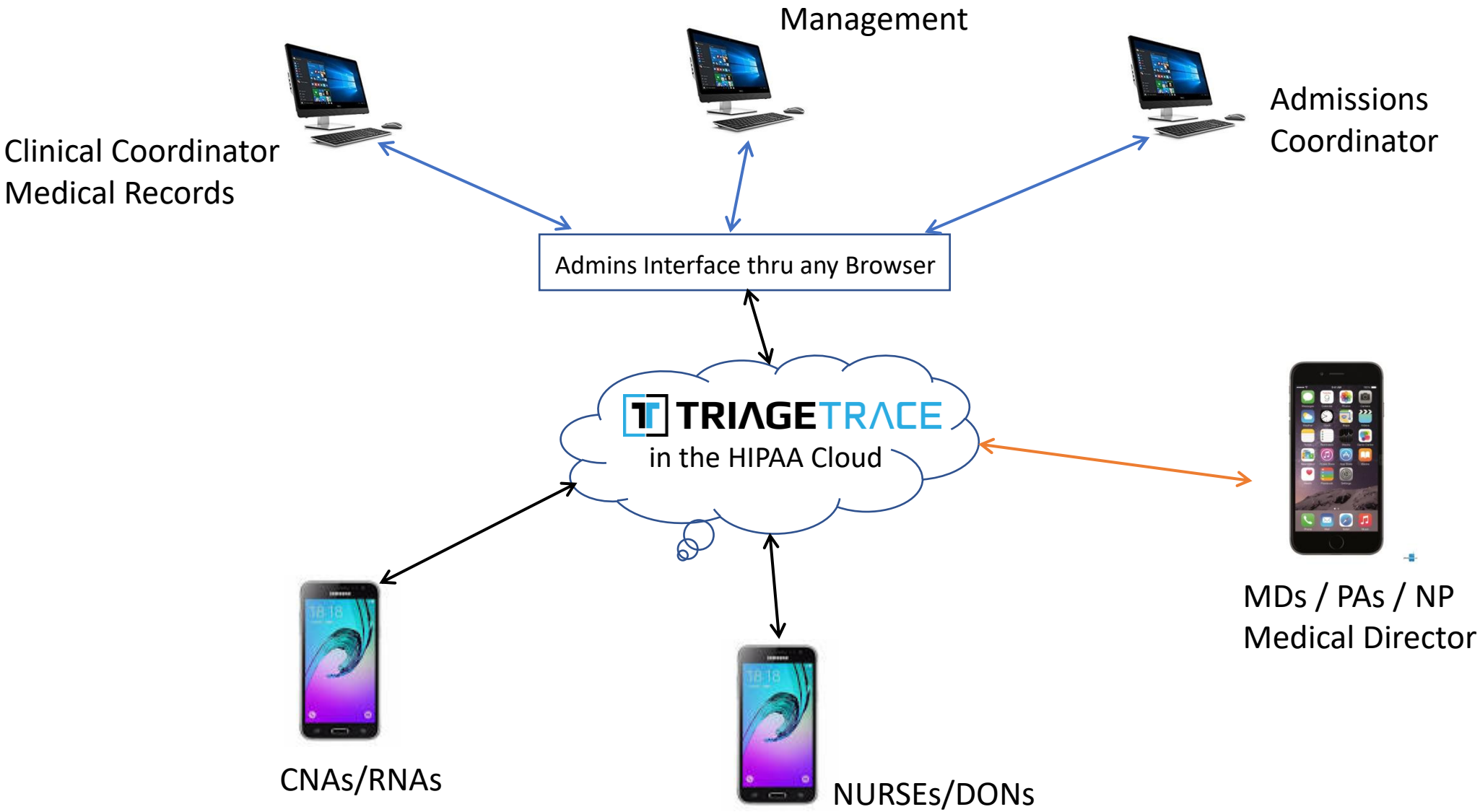
Service & Pricing

- TriageCERTS * $5,000/yr (less than $1/SNF bed/week)

  HIPAA compliant texting tool, Medicare Recertification management

- TriageTRACE * $12,000/yr (less than $10/SNF bed/month)
- TriageCERTS plus CoC management EAT/SBAR, Configurable care paths,

  30 day ER transfer trends/mitigation and operational analytics
- Consulting services as needed for setup, training, live support @ $50/hr


Management
Clinical Coordinator
Medical Records
Admissions
Coordinator
Admins Interface thru any Browser
TRIAGETRACE
in the HIPAA Cloud
MDs / PAs / NP
Medical Director
CNAs/RNAs
NURSEs/DONs

Key Features – 'communication is the documentation'

- Ineffective team communication is the root cause for 2/3rd of all medical errors in SNFs. Improved communications, productivity & documentation enables better care outcomes and cost savings
- Simplifies CNA, Nurse's & Physician's tasks for managing CoCs through episodic documentation, MDS analysis and reporting
- Physicians have instant access to historical information for making informed decisions, thereby improving care delivery & management
- Configurable Care Paths/Care Checklists, extensive trend analytics for minimizing 30 day readmissions and operational efficiencies

$ Value Proposition to SNFs

- Improved productivity adds up to significant cost savings, improved star ratings, leading to increased patient traffic
- ~$7K/year saved from ReCert lapses (average 7days@$1K)
- ~$3K/year saved in MR costs to compute 30-day transfer
- ~$3K/year saved overtime/nurse for documenting SBARs
- ~$3K/year saved with included HIPAA compliant texting
- Reducing preventable ER transfers could yield bonuses on CMS VBP program (>2% of annual reimbursements)

‘communication, productivity, readmission prevention’ why is it an even bigger deal now?

- Leveraging technology for connected care across hospitals, physicians and SNF care givers is needed to address the upcoming healthcare continuum
- The move to Value-Based Care and the Conditions of Participation means SNFs are being penalized for all cause 30 day readmissions up to 2%
- Hospitals tied into Bundles, ACOs, Health Plans share risk models with post acute Skilled Nursing Facilities, so collaboration is key to making informed decisions
- Per CMS 20% of Medicare fee-for-service patients will be readmitted to a hospital within 30 days, at an annual outlay of $26 billion, with 2/3rd considered avoidable
- Per CMS the average cost of a Medicare patient readmission is $14K and over 2/3rd of hospitals in California were penalized by CMS for all cause preventable readmissions