# 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!
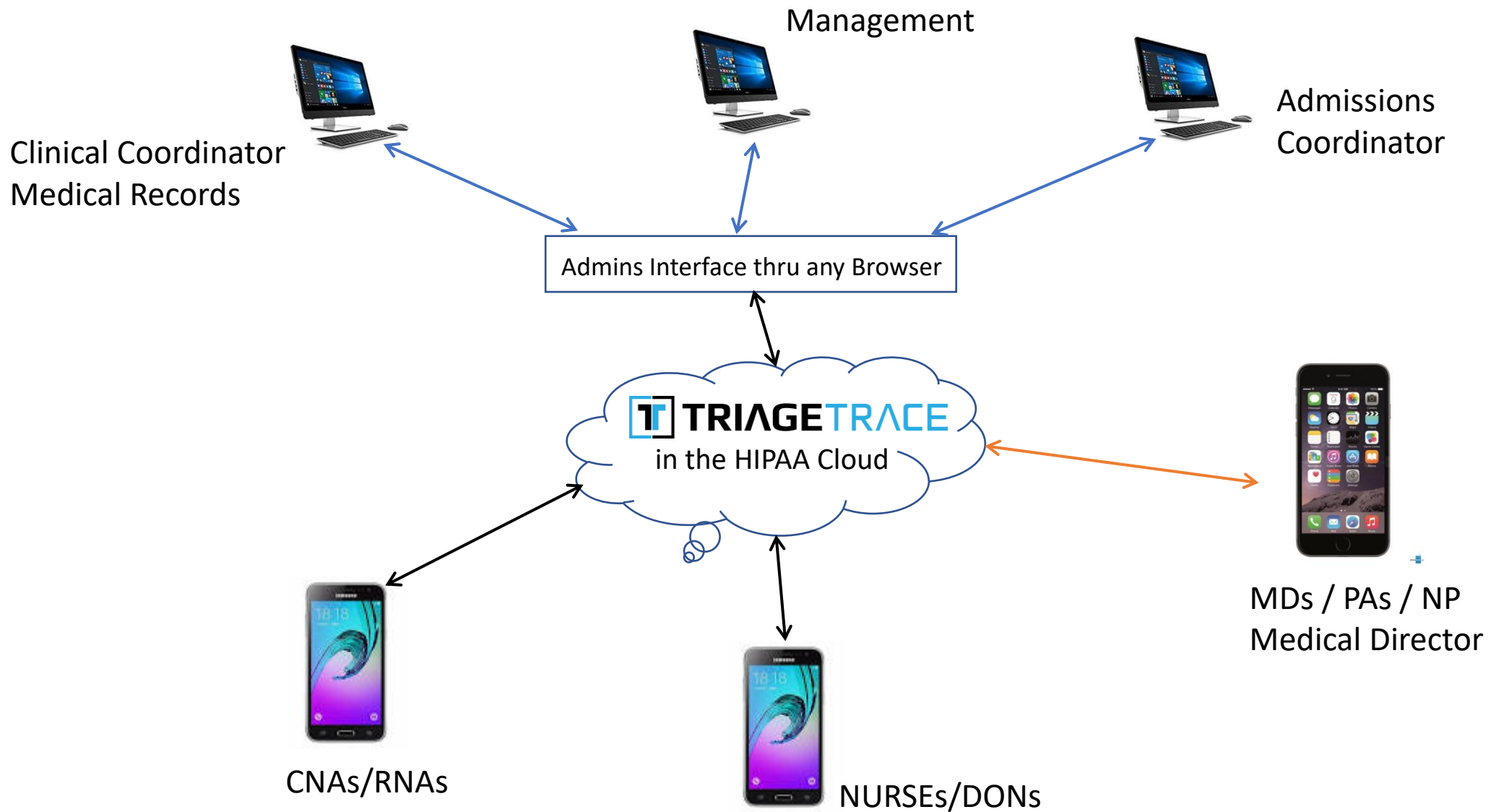
# Key Features – 'communication is the documentation'

- Ineffective team communication is the root cause for 2/3$^{rd}$ 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)

# Product Family

- <u>TriageCERTS</u>              *  $5000/yr    ( less than $1/bed/week )

  HIPAA compliant texting tool - Unlimited users, hosting, email support

  Recertification management and 30 day ER transfer analytics

- <u>TriageTRACE</u>              + $7000/yr

  Adds CoC management EAT/SBAR, Configurable care paths, Analytics

- <u>TriageTRACE+</u>              + $TBD      (adds teleconsultation – coming soon)

- Consulting services as needed for setup, training, live support @ $50/hr

TRIAGETRACE
A Digital SNF2.0 Platform

# '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