



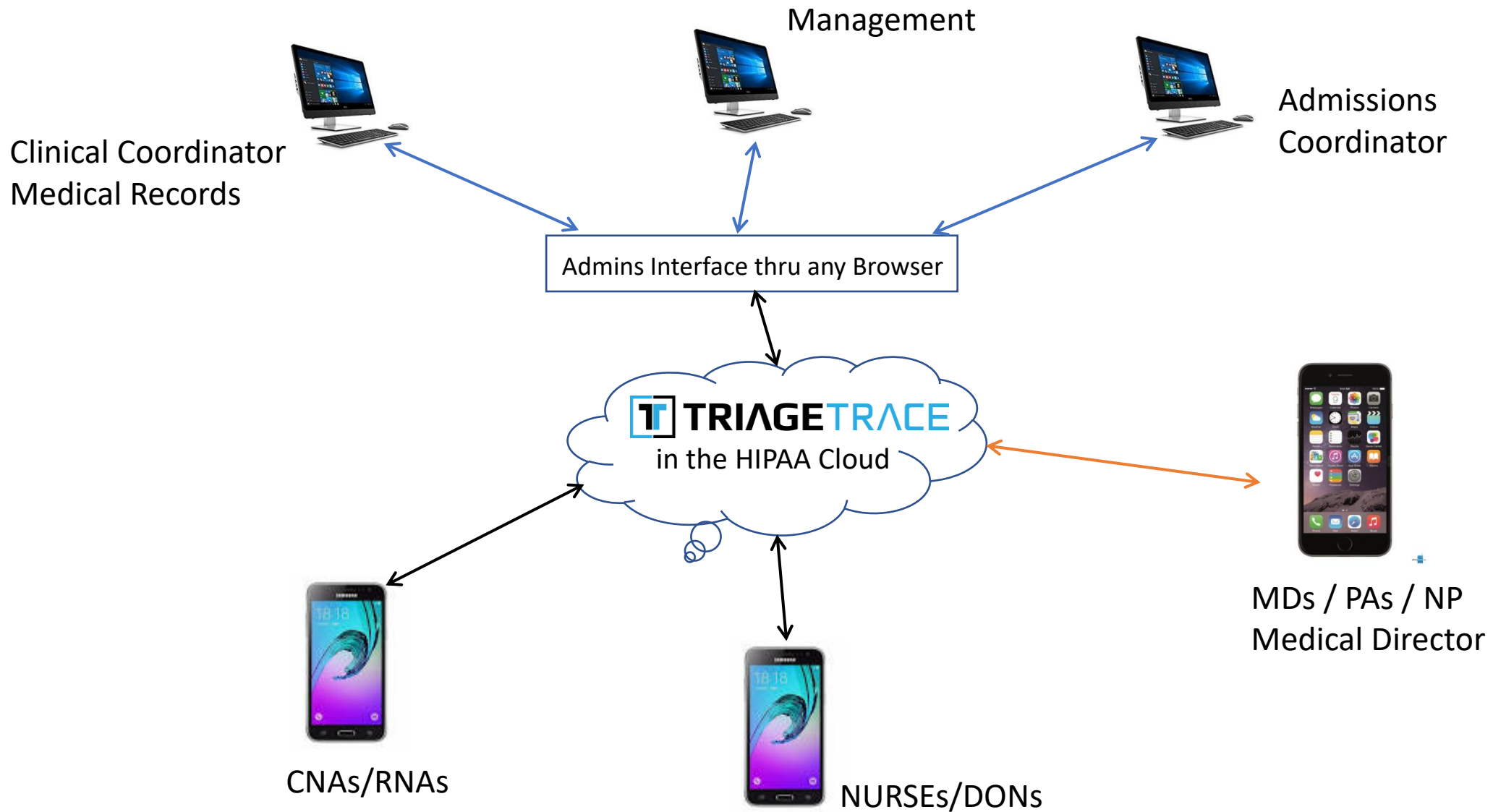
TRIAGETRACE

Digital Skilled Nursing using smart phones & tablets



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!



The 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
- Leads to cost savings from digitizing ReCerts and reduction in 30-day transfers to ER while enabling remote CPT codes for physicians

\$ Savings – an example

- ~\$7K/year saved from ReCert lapses (average 7days@\$1K)
- ~\$3K/year saved in MedR 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)
- Improved productivity adds up to significant cost savings, improved star ratings, leading to increased patient traffic

Why 'readmissions' is 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 upto 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

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Thank You