

Reducing Patient Readmissions and Increasing RPM Revenue Through Patient Engagement

The Challenge

Reduce Costly COPD HRRP penalties for economically-disadvantaged populations

The Hospital Readmission Reduction Program was designed by CMS to encourage hospitals to monitor the 30-day readmission rate of patients who were discharged home. It is a pay-for-performance program that lowers payments to hospitals for various chronic conditions like, heart failure, pneumonia, and COPD. For each eligible hospital, a payment adjustment factor is calculated. This adjustment factor estimates what percent a hospital's payment is reduced which in some cases can be as high as 3%.

But not all patients are created equal. Patients who identify as lower socio-economic have been shown to be a positive predictor of readmissions¹ and typically these patients have multiple social-determinants, such as food insecurity, access to medication, and home issues that affect readmissions. According to research, these non-medical concerns make up more than 70% of health outcomes.² That is why connecting with this population outside the hospital can have a positive effect on satisfaction and outcomes.

regards to COPD readmissions is a key focus for our hospital. With SynsorMed we are able to intervene quicker and ensure we can sustain long term health equity.”

– Vice President of Respiratory Services
637- Bed Hospital in Georgia

Here is how SynsorMed works with hospitals to assist with this patient population after discharge for COPD to reduce readmissions and encourage better patient behavior.

How We Work

Through effective mobile monitoring, SynsorMed keeps doctors, patients and caregivers connected after discharge like never before. The data we provide is actionable and easy for patients to understand.

From our experience, technology alone is not able to effectively engage this particular patient population. That is why SynsorMed provides a complete solution for our clients. Not only do we provide a platform that quietly tracks a patient's process and monitors clinical areas of concern, but we are able to provide mobile and connected devices for patients who are in need. With our clinical staff, we are able to handle simple patient requests for medication refills, home concerns, and patient transportation needs through local third-party partners.

Our complete care management turnkey product and service allows us to partner with our hospital clients to increase revenue through the new CPT remote patient monitoring codes. With our services, clients can bill up to \$60 per patient per month for viewing the physiologic data coming from our platform. A typical hospital or clinic can see revenue up to \$12,000 a month.³

Sources:

1. "Socioeconomic Status as an Independent Risk Factor for Hospital Readmission for Heart Failure."
2. University of Wisconsin County Health Rankings
3. Assumptions: 200 patients under monitoring. Minimum of 30 min per month per patient

Validation of Outcomes

A large non-profit healthcare center in Middle Georgia struggled with COPD readmissions as high as 35% from patients in neighborhoods where the median income was less than \$23,000 a year.

It was determined that focusing efforts on this cohort, which made up 20% of the total number of COPD admits, would assist in keeping readmissions down. During a 6-month prospective cohort study, SynsorMed was able to reduce readmissions to 12%. This was an improvement of over 42% from a similar constructed cohort.

The Results



93%

patient usage



42%

reduction in
readmissions



85%

patients would
recommend to a
friend

Patients Love SynsorMed



“I don’t really have anyone checking on me regularly. I feel like this helps”

- 65-year-old male COPD patient



“Was going to call 911 but the nurse reached out from the app and I feel better”

- 60-year-old female CHF and COPD Patient

“Guiding providers and payers toward better care at home for their most vulnerable patients”

ABOUT SYNORMED

SynsorMed provides healthcare discharge teams with a complete reimbursable patient monitoring system. Our unique two-step approach combines our mobile solution with clinical services to ensure patient compliance with daily status updates, education and physiologic data through connected devices. We are able to proactively recognize medical and non-medical issues before a readmission occurs.

